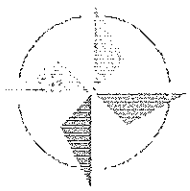
Appendix

Public Comments to the Rhode Island State Health Care Innovation Plan



CharterCARE
HEALTH PARTNERS

WWW.CHARTERCARE.ORG

December 3, 2014

The Honorable Elizabeth Roberts
Lieutenant Governor
State House Room 116
Providence, RI 02903

RE: Rhode Island's State Healthcare Innovation Plan

Dear Lieutenant Governor Roberts:

Thank you for the opportunity to provide comments on the draft State Healthcare Innovation Plan (SHIP). I congratulate you and your office for the leadership you have provided in the effort to create the SHIP. I also appreciate the work of the state agencies and the stakeholders that assisted in the development of the SHIP.

CharterCARE Health Partners has been supportive of the broad effort to transform our Rhode Island health system to improve the health of our citizens and increase the overall quality of care in the state, while also making care more affordable for all. We believe that moving from volume to value through changing the provider reimbursement system is key to transforming our delivery system.

We have recently selected a partner, Prospect Medical Holdings, Inc. (PMH), who has the expertise and capital to support CharterCARE's move to value based reimbursement in contracts with payors. A subsidiary of PMH, Prospect Medical Systems (PMS), currently manages 185,000 enrollees of health plans in capitation-based contracts ranging from medical risk to full medical and institutional risk and has done so for more than 20 years. Both PMH and PMS are collectively referred to as Prospect. PMH hospitals in Los Angeles have now contracted to assume and manage institutional risk for 35,000 Medi-Cal (California's Medicaid program) beneficiaries. Though our partnership with Prospect, we are bringing these capabilities to Rhode Island and are willing to share them with other providers as well as the payors in our community.

We have been working with Blue Cross Blue Shield of Rhode Island (BCBSRI) to develop both a more affordable small group product as required by the Office of the Insurance Commissioner and a capitation-based Medicare Advantage product. In order to build the capability to work with BCBSRI under value-based reimbursement, CharterCARE, in partnership with PMH, has established an entity capable of assuming and managing full risk

contracts when the time is right. Further, we have been collaborating with our own medical staff to create a physician group capable of assuming and managing medical risk with the contractual assistance of PMS. We have also met with most of the other organized physician groups in the community, and we are seeking effective ways to collaborate with them and provide value-based services to them. We have also met with other hospital systems and their affiliated physicians to invite them to join together in a collaborative and comprehensive network with the purpose of moving to risk-based contracts across Rhode Island sooner rather than later.

The SHIP proposes many innovations to improve our Rhode Island healthcare system. Although the ideas are good—it may be difficult to implement all of them in the near future. One of the proven concepts that is discussed throughout the document as necessary for us to develop an efficient, highly coordinated delivery system that produces quality outcomes is providers assuming and managing risk. However, we think that the SHIP has taken too cautious an approach to this important issue. While reticence to embrace a robust risk-based provider contracting model is understandable, the benefits to our healthcare system are simply too great to allow caution to mitigate the need for us to move rapidly to implement this key strategy for the provider community in Rhode Island. This is especially true now that the expertise and capability to implement this strategy is available to the providers and citizens of Rhode Island through CharterCARE's new partnership with Prospect.

It is well documented that proven innovations in healthcare take an inordinate amount of time to make their way into the community standard of care, even with solid scientific evidence and community support behind them. However, the need to implement the transition from volume to value through risk-based reimbursement to providers has never been greater, and we think that the SHIP should offer clear support for this strategic priority, including specific support for providers and payors willing to innovate in this area. Specifically, here are our recommendations for inclusion in the SHIP:

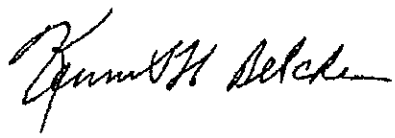
1. **Global Risk or Capitation**. The benefits of global risk or capitation in provider reimbursement should have a more prominent position in the discussion of the move from volume to value—capitation is generally referred to as something for the future. The SHIP should make clear that while these arrangements may not be prevalent in Rhode Island today; they are successfully reducing costs and improving quality in many other parts of the country.
2. **Policy Support**. The SHIP should explicitly support moving to global risk models in the near term in Rhode Island, rather than favoring an unnecessary first-step transition through ACOs, bundled payments and upside risk arrangements. These other value-based reimbursement methodologies can and should co-exist with global risk and capitation but should not be considered pre-requisites;
3. **Pilot Programs**. The SHIP should encourage provider organizations that possess the demonstrated capabilities to assume and manage global risk --financially, administratively, technologically and clinically—to do so and with the strong support of payors, government and other providers;
4. **Regulatory Support**. The SHIP should ask the Department of Business Regulation and the Office of the Health Insurance Commissioner to encourage global risk pilot implementations now for those providers and payors licensed in Rhode Island that are

willing and capable of implementing these strategies. The fact that Rhode Island's current regulatory scheme does not correspond neatly to global risk strategies should not stand in the way of these pilot programs but should be a reason to accelerate implementation for purposes of providing real-time data to the SHIP as it considers legislative or regulatory changes over the longer term.

We are in solid support of the goals of the SHIP. We also believe that the SHIP should encourage and accelerate a necessary public/private partnership to lead innovation to the more efficient, more affordable, more coordinated and higher quality healthcare system we all want in Rhode Island.

I hope you find these comments helpful as the final draft of the SHIP is completed. We thank you for the opportunity to comment and look forward to providing support to the realization of the SHIP. Please feel free to contact me with any questions you may have regarding our comments.

Sincerely,



Ken Belcher
CEO
CharterCARE Health Partners

RHODE ISLAND KIDS COUNT
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To: Lt. Governor Elizabeth Roberts

From: Elizabeth Burke Bryant, Executive Director
Jim Beasley, Policy Analyst

Date: November 26, 2013

Subject: Rhode Island's State Healthcare Innovation Plan

Rhode Island KIDS COUNT respectfully submits the following comments to the Office of the Lt. Governor regarding the Healthy Rhode Island State Healthcare Innovation Plan.

Support for State Efforts, including the SHIP

We recognize and thank the Lt. Governor, Governor's Office, the Executive Office of Health and Human Services, the Office of the Health Insurance Commissioner, the Department of Health, and HealthSource RI for their collective leadership in moving healthcare innovation and reform forward in Rhode Island. The State Healthcare Innovation Plan (SHIP) represents an important opportunity to continue to optimize and improve Rhode Island's healthcare system. We appreciate the inclusive planning process for the SHIP and have found the detailed outline of the state's current healthcare system useful. We are also supportive of state efforts to further explore ways to bend the medical cost curve, link payment to health outcomes, improve the quality of healthcare, and enhance the quality of health across Rhode Island.

Recommendation: Add a Focus on Children and Youth to the SHIP

Rhode Island KIDS COUNT strongly urges the state to consider a more robust inclusion and focus on children and youth's health care and health outcomes within the SHIP.

Children's and adolescents' engagement with the healthcare system is uniquely different than with adults. Child and adolescent health is more focused on enhancing and continuing developmental progress, while adult healthcare focuses more on health maintenance. Unlike adults, children and youth are dependent on parents/care takers and large support networks, which include family, child care providers, teachers, and others, for accessing and receiving care. Children and youth are also, for the most part, predominantly healthy, while many adults suffer from a large number of common chronic conditions (i.e. heart disease, diabetes, and hypertension). This divergence in health status has resulted in child/adolescent medical costs being significantly lower than their adult counterparts. Additionally, the combination of EPSDT mandates and new pediatric Essential Health Benefits required by the *Affordable Care Act* builds a framework of inclusive and comprehensive medical, dental, and behavioral health screening, diagnosis, and treatment for children and youth. RIte Care, in particular, has proven to be a model for setting health outcome goals, delivering quality, conducting evaluation, ensuring public transparency, and incentivizing

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as well as holding carriers accountable. These differences in benefits, carrier requirements, health status, degree of autonomy, care needed, services provided, challenges faced, and medical cost all highlight the need for a specific focus on children's health within the SHIP. Value-based payments, models of care, workforce needs and analysis, community health team membership and responsibilities, provider training and education, behavioral health services, patient engagement strategies, technology reforms, and all other proposed SHIP innovations need to take into account the perspective and needs of children, which very well may differ from adults.

It is also recommended that the SHIP explicitly analyze, account for, and incorporate the long-term savings that children's access to routine, comprehensive primary care and preventive services yields in the long run. We believe the medical cost savings produced by investments in child and adolescent comprehensive and preventive care are just as significant and may even be comparable to those found within other segments of Rhode Island's population. Furthermore, we strongly believe the savings achieved from investments in comprehensive, preventive child and adolescent care (including medical, dental, and behavioral health) is a vital and necessary component in reducing long-term medical spending. Rhode Island has had a strong commitment to children's health as represented by 94% of children having health insurance, which is 10th best in the country. We view the SHIP as an opportunity to further build upon Rhode Island's successful track record for children's health and to eliminate remaining gaps in coverage and care. Including child specific savings data and incorporating them into shared-savings arrangements will be an important catalyst for carrier and provider endorsement and change across all insurance types and will hopefully help the state achieve near universal child/adolescent coverage and care.

Recommendation: Keep the Focus on Behavioral Health

Rhode Island KIDS COUNT fully supports and welcomes the inclusion of behavioral health integration throughout the SHIP. Children's mental health is one of the indicators for which we track in our annual *Factbook* publication. The most recent-available data show a 39% increase of hospitalizations among children under age 18 with a primary diagnosis of a mental disorder since 2001. Best available data also show that in Federal Fiscal Year (FFY) 2012, 291 children and youth under age 18 with a psychiatric diagnosis were in need of inpatient treatment at psychiatric hospitals or in another placement in the community, but had to wait for one or more days in emergency departments and/or be admitted to medical floors at acute care hospitals. Also during that time, Bradley Hospital reported having an average of two kids per day who were ready to leave the psychiatric hospital for a "step-down placement" of lesser clinical intensity, but were unable to do so due to a lack of availability or lack of safe placement either at a treatment program or at home. All of this collective data show the apparent need for increased access to and integration of behavioral health care for children and adolescents. When designing or implementing behavioral health SHIP innovations, we encourage the state to take into account the unique needs of children and adolescents. We also call for the examination of pediatric and adolescent behavioral health provider capacity for both in-patient and out-patient services and that any gaps in care found, when able, be addressed through SHIP innovation efforts.

Recommendation: Add a Focus on Oral Health

Rhode Island KIDS COUNT would like to see a more robust inclusion of oral health into the SHIP. Research has shown that poor oral health has immediate and significant negative impacts on children's overall health, school attendance, and academic achievement. Despite having an

immediate and long term impact on overall health, oral health remains a siloed and optional form of coverage and care in Rhode Island's healthcare system. Efforts need to be made across all ages and groups, but especially children, to better incorporate and integrate oral health with medical care and coverage. Promotion and access to dental care and the establishment of a dental home should be included in all relevant SHIP provider and reimbursement models/innovations. The SHIP should also focus on and explore reimbursement models that increase access to dental care, especially for those children with Medicaid fee-for-service dental coverage and further maximize the pediatric dental component of Essential Health Benefits. Evidence-based prevention strategies, such as seeing a dentist by age one or soon after the first tooth erupts, should also be promoted and incorporated into relevant SHIP innovation plans, reimbursement models, shared-saving arrangements, and evaluation efforts. At a minimum, increased access to oral health should be incorporated into SHIP goal number 3 "Improve the Quality of Healthcare in Rhode Island" and should build upon the success of RIte Smiles in increasing the number of dental providers serving children with Medicaid coverage, which grew from 27 participating providers in 2006 to 406 in September 2012.

Recommendation: Keep the Focus on Health Equity
Rhode Island KIDS COUNT is very supportive of the increased focus on social determinants of health within the SHIP. Throughout the annual *Factbook,* the varying health outcomes of children and families that are associated with differing health insurance status/payers, geographic locations, race/ethnicities, and economic well-being are highlighted. All too often, the children and families with the worse health outcomes are those who either have no health insurance, live in poverty, reside in one of the four core cities (Central Falls, Providence, Pawtucket, or Woonsocket) or are of minority races and/or ethnicities. The SHIP represents a unique opportunity to reduce these persistent and long-lasting disparities with market-wide innovation reforms and initiatives. We encourage the state when designing or implementing health equity measures of the SHIP to not only focus on disparities mentioned previously, but to also include former foster youth, children with special needs, LGBT youth, and homeless and runaway youth as populations falling under this work and that their specific healthcare needs, which may be different from each other, adults, and other children, are addressed explicitly in relevant SHIP innovations.

Recommendation: Add a Focus on Evidence-Based Programs & Emerging Initiatives
Rhode Island KIDS COUNT encourages the state to leverage existing evidence-based programs and initiatives when implementing or designing SHIP innovations. Programs such as Healthy Families America, Nurse-Family Partnership, First Connections, Parents as Teachers, and Early Intervention should be considered for potential large scale implementation and inclusion within the SHIP. In addition, emerging ideas and projects such as the Department of Health's Primary Care Trust as well as the Patient-Centered Medical Home – Kids initiative, which is sponsored by the Office of the Health Insurance Commissioner and the Executive Office of Health and Human Services, should also be investigated and analyzed as potential SHIP efforts.

Recommendation: Emphasize Evaluation
Evaluation will play an important role in measuring whether SHIP innovations have achieved their stated goals of lowering medical spending, increasing quality of care, and improving health outcomes. Rhode Island KIDS COUNT encourages that the following child-specific measures are included in SHIP evaluations that focus on child well-being and health: breastfeeding,

women receiving delayed prenatal care, preterm births, low birthweights, infant mortality, childhood immunizations, children's insurance status, children's access to dental care, children with lead poisoning, children with asthma hospitalizations and emergency room visits, childhood obesity, births to teens, teen substance abuse, and children's mental health. School attendance, as well as academic performance and school-based self-reported surveys such as the *Rhode Island Youth Risk Behavior Survey* and *SurveyWorks!* at all grade levels should also be included in SHIP evaluation efforts. We believe optimal health outcomes will reflect not only improved physical health, but also improved educational performance and cognitive development and well-being. Optimal health will also be shown in the reduction of adverse measures including teen births, substance abuse, prevalence of depression, and exposure to environmental harms including lead, violence, and poverty. We acknowledge that some of these measures go beyond the traditional scope of evaluation, but emerging research has shown the high level of interconnectedness of child well-being to health, education, safety, and economic well-being indicators. As such, any SHIP evaluation effort that focuses on child well-being and health should be broad in scope and interdisciplinary in nature.

Closing

Rhode Island KIDS COUNT thanks Lt. Governor Roberts and other state partners for their continued leadership in optimizing and enhancing Rhode Island's healthcare system. Rhode Island has always been a leader in children's health and the SHIP represents a unique to opportunity build-upon this proud tradition, scale evidence-based services for children and families, minimize persistent health disparities, and reduce known behavioral and oral health gaps in care. We believe the recommendations we suggest can further enhance the SHIP. Rhode Island KIDS COUNT appreciates this opportunity to comment and welcomes the opportunity to further discuss our recommendations.

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Office of Lt. Governor
State House Room116
Providence, RI 02903!
ATTN:PublicComments

November 26, 2013

Good afternoon Lt. Governor,

The Rhode Island Parent Information (RIPIN) is pleased to be able to provide comments relative to the State Health Care Innovation Plan. Thank you for the opportunity to assist your office and Rhode Island in coordinating our healthcare system.

Respectfully,

Stephen Brunero

Stephen Brunero
Executive Director
Rhode Island Parent Information Network

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November 25, 2013

The Rhode Island Parent Information Network (RIPIN) welcomes and appreciates the opportunity to review the State Health Innovation Plan (SHIP) document and to extend our gratitude to the Healthy RI Team for the inclusive statewide collaboration from which this plan has been developed. RIPIN values the opportunity to express our support and provide suggestions and comments to assist Rhode Island in becoming the healthiest Patient Centered state!

RIPIN serves as the voice for consumers, particularly including individuals with disabilities as well as children and families. For this reason RIPIN will focus comment relative to overall vision of the SHIP plan, Community Health Teams (CHT), Patient Centered Medical Homes (PCMH) and Population Health.

Center for Medicaid and Medicare Services (CMS) issued states guidance on Quality Considerations for Medicaid and CHIP programs on November 22, 2013 at:

http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html

RIPIN will use this guidance as a framework to offer our recommendations particularly in regards to children as well as those with disabilities.

VISION

"In order to achieve this holistic framework, the state believes it is necessary to encourage and support the organization of payers, physicians, hospitals and other healthcare providers into coordinated care teams using payment models supported by the Centers for Medicare and Medicaid Services"

RIPIN would suggest weaving the consumer/patient experience as well as defining the patient as the center of health care reform. While organizing the payment and the providers is critical, it is necessary to develop health planning that recognizes the patient/person's health beginning in infancy, as the primary goal of the planning.

Community Health Teams

Indicated within the SHIP is a focus to develop Community Health Teams that will target high and rising risk populations. RIPIN suggests this model be utilized within clinical settings whenever possible to

improve integration, care-coordination, and build upon the health team model which is clearly seen in the Patient Centered Medical Home. Building from within a medical practice or working directly with the payers will enhance the ability to track data, measure and monitor the success of the model. Through the application of CMS's Quality Improvement strategies including goal setting, interventions, metrics, target, transparency and feedback, and by prioritizing provider partnership efforts from within the medical setting would serve to enhance Rhode Island's ability to experience success.

RIPIN in partnership with the Executive Office of Health and Human Services (EOHHS) and Medicaid providers has demonstrated success utilizing the Peer Navigator model and CHT outside the medical as evidenced by the Communities of Care (COC) model. RIPIN also has developed the Pediatric Practice Enhancement Project (PPEP) in partnership with Department of Health (DOH) providing care-coordination for children with special health care needs and in working within the medical setting as part of the medical care team. Both of these models have clearly demonstrated to successfully improve health outcomes for consumers as well as show financial savings.

In response to the licensure of Community Health Workers, RIPIN expresses concern that a licensure requirement may be counterproductive as it would potentially be too time consuming, and too costly as well create barriers to current successful and culturally competent programs. RIPIN recognizes the value of elevating the profession of Community Health Workers, however, required licensure at this time is felt to be unnecessary.

The success of the CHW's lie within their abilities to focus and connect with the diverse populations they serve. Alternative to licensure, the Department of Health provides a community health workers certification that is nationally recognized and can serve as basic framework for all CHW's. Any and all effort should be made to not only to financially support the process of certification, but also provide flexibility among the variety of CHW specialties.

Patient Centered Medical Home

Establishment of the Patient Centered Medical Home (PCMH) as the ***standard*** of health care delivery across all populations should be the goal for Rhode Island. Rhode Island should aim to provide ***all*** Rhode Islanders access to a PCMH by 2020. The PCMH model aligns with Rhode Island's investment in data collection and analysis, and it will transition our delivery system toward a preventative patient focused model. Every effort should be made to tool ***all*** practices toward this model of care and shift Rhode Island to be nationally ranked #1 in Patient and Family Centered Medical care.

When applying the CMS guidance to Quality Improvements, goal setting, interventions, metrics, target, transparency and feedback, PCMH can provide the launching pad for innovations, payment transformation, and public health initiatives quite effectively as demonstrated with the current state initiative CSI. Expanding upon this successful model will ensure we meet our goals as well as to become the National leader in PCMH model.

Population Health

RIPIN would oppose the proposal of a Health Risk Assessment strategy to support employers and payers to require the completion of a Personal Health Risk Assessment. The proposal should be established in a consumer oriented manner. RIPIN would suggest either a consumer incentive model or voluntary model.

Stronger focus on the children, youth, and families should also be included in the elements of innovation efforts. We understand the impact of social determinant on health, particularly for our most vulnerable populations and children. The proposed plan in its current state, should have a stronger focus on children and families. All programming and innovations should include the develop of similar programs for children with a strong public health campaign attached within the innovation.

RIPIN would also encourage enhancing curriculum development to schools, workplaces, as well as within health settings as a long-term cultural shift toward a fully engaged medical system. Developing strategies that will promote healthy beginning with our children will assist our state moving toward a Healthy 2020.

Additional comments:

- A focus to move the chronically ill or disabled into community settings should be clearly intended and thoroughly developed.
- Integration of Behavioral Health in Primary Care strategies as opposed to co-location.
- Stronger focus on workforce development that will include community based programming to transition the elderly, and individuals with disabilities toward community-integrated settings.
- Inclusion of the state Palliative Care Planning efforts to align with the health programs for the chronically ill.
- Development of state health Indicators that will allow our state to use the data to actively improve health outcomes.

RIPIN is open to offering additional information and suggestions that will assist the Healthy Rhode Island team in their finalization of the innovation plan. RIPIN is an active state partner committed to the efforts to move RI toward a Healthy 2020. RIPIN thanks the Health RI Team for their hard work and dedication to this process and constant desire to improve the health of all Rhode Islanders.

Sincerely,

Stephen Brunero, Executive Director

Green & Healthy Homes Initiative

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www.ghhi.org

November 26, 2013

Mr. Daniel J. Meuse
Deputy Chief of Staff
Office of the Lieutenant Governor
82 Smith Street
Providence, RI 02903

Dear Mr. Meuse:

I have been encouraged by several colleagues to reach out to you and make the connection between the Green & Healthy Homes Initiative™ (GHHI) and the Rhode Island State Health Innovation Plan (SHIP). GHHI works to improve unhealthy and inefficient housing to combat the negative costs of chronic environmental health concerns such as asthma, lead-based paint poisoning, and trip and falls as well as energy related costs resulting from non-efficient housing.

Having recently received a draft version of the SHIP, I see many instances where GHHI could be a strong community partner to help Rhode Island create a new sustainable health system. I believe it would be mutually beneficial to meet with you and your colleagues to brief you on the work of GHHI, learn first-hand more about the SHIP, and to discuss ways we may be able to work together. Specific examples of how GHHI can help address challenges identified in the SHIP are outlined in the attached document, along with more information about GHHI.

I hope that you find these materials informative and that we may be able to connect in the near future to discuss more about how GHHI may be able to be a part of helping meet the goals of the Rhode Island State Health Care Innovation Plan.

I look forward to hearing from you soon.

Sincerely,

Mark A Kravatz

Mark A. Kravatz
Green & Healthy Homes Initiative

CC: Jennifer Wood

GHHI Contributions to SHIP Implementation

1. Challenge: Care delivery is fragmented.
   Innovation: Grow PCMH model.

GHHI has participated in local partnership discussions on strengthening the PCMH model through integration of GHHI's resident health educators, who work with patients and their families to facilitate home health, with clinical staff including doctors and nurse care managers. Through a burgeoning collaboration with Dr. Jeffrey Borkan, physician in chief of the Department of Family Medicine and Dr. David Ashley, Medical Director of the Family Care Center at Memorial Hospital, GHHI is proving that an innovative approach to healthy housing will have positive effects that spans across several systems including reducing costly chronic hospital visitations, reducing chronic school absenteeism, lowering utility costs, and stabilizing neighborhoods. In partnership with Brown Medical School, Memorial Hospital in Pawtucket, Johns Hopkins Health Care and GHHI's flagship office in Baltimore, we have recently applied for an $8.5 million Centers for Medicaid and Medicare Innovation Grant that if awarded will provide 400 GHHI housing interventions for high risk families in Central Falls (5% of CF's housing stock). This innovative and transformative primary prevention model uses housing as a platform for health to reduce medical costs associated with high-cost and avoidable home-based environmental health triggers that contribute to asthma exacerbations that result in inpatient hospitalization and emergency department visits. If awarded, this grant will build upon the learned lessons of a successful GHHI phase I pilot program in the Olneyville neighborhood in Providence that delivered GHHI interventions to 135 homes (2012-2013), Phase II in Providence (60 homes, Spring of 2014) and a Phase I statewide expansion to Pawtucket, Central Falls, and Woonsocket (50 units, Spring 2014) as well as the expertise of GHHI colleagues in 17 cities across the country.

More information about this partnership is attached as supplementary materials including the Executive Summary of the proposal and recent articles about GHHI and our partners.

2. Challenge: Care Transitions are costly and lead to poorer health outcomes.
   Innovation: Expansion of Community Health Teams will provide resources to support, coordinate and aid patient transitions from hospital to/or LTC or home.

GHHI's resident health educators have the potential to be an integral component of a health care transition team for families suffering from the effects of poor housing, such as exacerbations of asthma that result in inpatient hospitalizations, by serving to help patients returning to their homes and ensuring that home-based risks for asthma exacerbations are controlled. GHHI's reiterative in-home resident education is an essential component of assisting

patients with asthma as they transition home and come to understand the behaviors and environmental triggers that exacerbate asthma. The work of the resident health educators is complemented by the provision of household cleaning supplies and related items to help reduce allergens as well as physical improvements to the home by experienced contractors to address structural deficiencies that contribute to poor patient health.

3. Challenge: High risk population requires high intensity services and often over-utilizes the ED.
   Innovation: Community health teams based outside of provider practices

GHHI's housing interventions and associated resident education are designed to address home-based hazards that contribute to unnecessary use of high-cost medical services such as ED visits and inpatient hospitalizations. In GHHI's flagship Baltimore site, the model has proven effective with child patients exhibiting poor asthma management that result in medical utilization. For example, among 136 households that received GHHI's integrated services between 2010 and 2012, caregivers reported declines of 60% for hospitalizations and 24% for ED visits at six-months post-intervention among their children with asthma. GHHI is building partnerships in sites with MCOs and state health agencies to confirm these positive self-reports in health improvements with administrative data. As described in the attached proposal abstract, Neighborhood Health Plan of Rhode Island is one such partner that is supportive of the GHHI approach to improving patient health and is committed to data sharing arrangements that will help to verify pre-post utilization.

4. Challenge: Rising risk population requires greater awareness of risk, and access to information, prevention activities and screening.
   Innovation: Promote healthy lifestyle.

As noted previously, in the GHHI model resident health educators work in the home to help families become more aware of the housing risks as well as their own behaviors that contribute to poor health outcomes. For example, among caregivers of children with poorly controlled asthma, educators inform families on a range of behavioral changes such as adherence to an Asthma Control Plan, prescription adherence, cleaning activities, and smoking cessation, among others. Reiterative home visits by educators enables them to continue to work with families and provide needed support for health and maintaining the home intervention.

5. Challenge: Some Rhode Islanders can be disengaged and lack accountability for their own health and healthcare.
   Innovation: Provide Navigators, require Personal Health Risk Assessments, Marketing and Communication campaign, etc.

GHHI staff who work with families utilize a variety of tools and strategies designed to track outcomes and to help guide improved behaviors for personal health. In the Providence Olneyville GHHI pilot (2012-2013), resident educators implemented health and energy efficiency surveys that were used to track pre-intervention conditions and behaviors, while also using responses to the survey questions to tailor follow-up educational sessions with families. Personal health risk assessments could be implemented in much the same way.

6. Challenge: Community-based organizations vary in readiness to participate in health care.
   Innovation: Provide technical assistance services, collaboration group, empower CBOs to more directly address social determinants of health.

I am pleased to state that GHHI in Rhode Island is ready to participate in health care and has experience doing so as described in this letter. The health outcomes that GHHI seeks to improve in communities are directly attributable to the problem of social determinants of environmental health hazards, home-based hazards, and related economic inequities. GHHI is eager to be part of the solution.

7. Challenge: The state government provides little focus on or resources to address the social determinants of health.
   Innovation: Establish inter-agency education and information programs that articulate impact of social determinants of health on different agencies.

In Rhode Island we have demonstrated the ability to organize inter-agency partnership around housing and health and as described in more detail beginning on page 5. GHHI recently helped to organize the Rhode Island Alliance for Healthy Homes to align, braid and coordinate information, resources, and services for improving the health, safety and energy efficiency of all Rhode Island homes. Key Alliance partners include the Rhode Island Department of Health, Rhode Island Office of Housing & Community Development, Rhode Island Housing Resources Commission, Rhode Island Office of Energy Resources, Rhode Island Department of Human Services, Weatherization Assistance Program, Rhode Island Energy Efficiency Resource Management Council, Rhode Island Attorney General's Office and Rhode Island Housing.

What is GHHI?

GHHI streamlines housing intervention services by aligning, braiding, and coordinating partnerships representing multiple federal and philanthropic investments to provide the integrated delivery of services to low-income families in need resulting in much deeper and effective housing interventions. GHHI is a high quality, high impact approach to housing rehabilitation that drives public and private sector collaboration, streamlines service delivery, integrates energy and healthy housing interventions and develops better trained community-based green and healthy homes contractors. GHHI partner sites include 17 locations across the country with 45 communities seeking designation as "next generation" GHHI sites.

Originally founded in 1986 as the Coalition to End Childhood Lead Poisoning (Coalition) in Baltimore, MD as Parents Against Lead, a grassroots volunteer effort, the Coalition developed, implemented, and promoted programs and policies to eradicate childhood lead poisoning and further the creation of healthy homes. In 2008 the Coalition was charged by the Council on Foundations, White House Office of Recovery, HUD, CDC, EPA, DOE and the Open Society Foundations to lead the national efforts to integrate lead hazard control, healthy homes, and weatherization and energy efficiency work. This work was launched as the Green & Healthy Homes Initiative™ (GHHI). Directed by the Coalition, GHHI addresses the health and energy efficiency needs of a home through a holistic intervention model. In 2013 the Coalition transitioned its name to the Green & Healthy Homes Initiative.

The initial GHHI pilot project sites will serve to inform the national agenda by generating best practices and lessons learned in the area of integrated green and healthy housing assessment and interventions. Working in partnership with local jurisdictions and federal agencies, GHHI national has a tremendous potential to advance "whole house solutions" for environmental health, energy efficiency, and green strategies that will produce the reengineering of housing interventions and additional funding for lead hazard reduction and Healthy Homes interventions. GHHI is designed to produce measureable results that deliver healthier, more energy efficient homes, higher quality green jobs and increased economic opportunities for low income communities, and better health outcomes for children and families that results from leveraging the nation's investment in energy efficiency with critical lead hazard control and Healthy Homes interventions.

GHHI-Rhode Island Key Milestones at a Glance

- **July, 2009:** Neal Steinberg of the Rhode Island Foundation attends a White House Office of Recovery and Council on Foundations GHHI briefing in Washington, DC
- **October, 2009:** Providence is designated as a GHHI pilot site
- **April, 2010:** Providence conducts its first GHHI Providence Steering Committee meeting at the Rhode Island Foundation
- **June, 2010:** Providence attends the first annual GHHI Executive Leadership Institute in Baltimore, MD
- **November, 2010:** Providence secures $60k GHHI Onboarding grant from the Rhode Island Foundation
- **January, 2011:** Providence opens its 460 Harris Avenue office
- **February, 2011:** $3.2 million Lead Hazard Control Grant Secured (City of Providence)
- **March, 2011:** Providence Outcome Broker Hired
- **April, 2011:** GHHI Compact is signed. City of Providence is the first City in the country to sign GHHI compact
- **June, 2011:** Mayor Tavares co-sponsors US Conference of Mayors resolution supporting the work of GHHI
- **October, 2011:** City of Providence secures $850k from State Office of Energy Resources for weatherization upgrades, resident educator support, and pilot evaluation
- **November, 2011:** More than 20 MBE contractors complete comprehensive GHHI training and certifications
- **December, 2011:** Launch of Initial GHHI Providence Pilot
- **February, 2013:** Completion of GHHI Providence Pilot (135 Units)
- **May, 2013:** $2.5 million Lead Hazard Control Grant secured (Rhode Island Housing)
- **June, 2013:** GHHI Providence is host City for the National GHHI Executive Leadership Institute
- **July, 2013:** First meeting of the RI Alliance for Healthy Homes Steering Committee
- **September, 2013:** Rhode Island Foundation receives Secretary of HUD Award for Public-Philanthropic Partnerships for the Providence Phase I Pilot program
- **September, 2013:** GHHI completes first draft of its 360 page Green & Healthy Homes Rhode Island Compendium
- **October, 2013:** Public Launch of the Rhode Island Alliance for Healthy Homes

The Rhode Island Alliance for Healthy Homes

Building on a growing support for GHHI and recognizing an opportunity to expand GHHI's work to a statewide level, in June of 2013, the Rhode Island Alliance for Healthy Homes (Alliance) formed as a merger of the Department of Health's Healthy Housing Collaborative, the Housing Resource Commission's Healthy Housing Work Group, and the Green & Healthy Homes Initiatives Steering Committee. With a mission to align, braid and coordinate information, resources, and services for improving the health, safety and energy efficiency of all Rhode Island homes, the Alliance aims to provide a well-coordinated and collaborative structure to address GHHI related issues throughout all of Rhode Island. GHHI is the lead coordinating agency for the Alliance and supported by a Steering Committee representing the Rhode Island Office of Housing & Community Development, the Rhode Island Housing Resources Commission, the Rhode Island Department of Health Office of Healthy Housing, Rhode Island Office of Energy Resources, Rhode Island Department of Human Services, Weatherization Assistance Program, Rhode Island Energy Efficiency Resource Management Council, Rhode Island Attorney General's Office and Rhode Island Housing.

In October of 2013, more than 100 participants representing physicians, contractors, housing specialists, higher education, public health, energy auditors, community health workers, weatherization contractors, students, healthy homes advocates, home visiting professionals, nurses, community developers, planners, federal agencies, utilities, data specialists, construction specialists, asthma educators, and many more gathered at Rhode Island College to learn about the mission, vision and objectives for the Rhode Island Alliance for Healthy Homes.

The Alliance aims to coordinate the professional healthy homes community in Rhode Island. Value added for participants includes:

- Statewide leadership, planning and coordination on all GHHI related issues/ topics
- Healthy Housing braiding to meet GHHI standards
- Braiding of housing, health, education, and energy efficiency data
- Key reports/ documents (compendium, annual report(s), etc.)
- Professional community development/ networking
- Access to primary healthy housing leadership
- Leveraging Partnerships
    - More competitive for funding
    - Stronger policy coordination
    - Streamlining GHHI supplemental services (resident education, housing assessments, behavioral health specialists, etc.)
- Development of best practices/ standards
- Professional training, learning and development

- Coordination of healthy housing expertise and knowledge
- Communicating the story of families most in need of GHHI standard housing and raising awareness on social justice issues related to unhealthy housing

(Please see the attached materials for more information about the Alliance)

Green & Healthy Homes Initiative Asthma Intervention Model

The Green & Healthy Homes Initiative (GHHI) is an innovative and transformative primary prevention model that uses housing as a platform for health to reduce medical costs associated with high-cost and avoidable home-based environmental health triggers that contribute to asthma exacerbations that result in inpatient hospitalization and emergency department visits. Designed and managed by the Coalition to End Childhood Lead Poisoning, GHHI is being implemented in 17 communities nationally.

With an investment of $8,529,121 of CMS Health Care Innovation Challenge funds, GHHI will deliver on the three-part aim using an effective intervention of clinical referrals and follow up coupled with in-home client education, healthy housing assessment, and asthma trigger mitigation services. The program will deliver interventions to 1,750 low-income Medicaid/CHIP patients ages 2-64 in Maryland and Rhode Island. GHHI's key partners in this application include Johns Hopkins Health Care, Priority Partners MCO, AmeriGroup, Brown University's Alpert Medical School, Memorial Hospital of Rhode Island, Thundermist Health Center, Blackstone Valley Community Health Center and Neighborhood Health Plan of Rhode Island

Through the strategy set out in this proposal, GHHI and its partners will:

- Improve health outcomes for children enrolled in Medicaid as measured by the prevention and reduction of asthma related inpatient hospitalizations, emergency department visits, urgent care visits, and rescue medication use;
- Improve service delivery to high risk Medicaid populations through integrated community health practices via an expanded partnership and coordinated infrastructure of health and housing stakeholders;
- Reduce costs to Medicaid and CHIP for the treatment of asthma for 1,750 high cost burden asthma patients in Maryland and Rhode Island enrolled in the program;
- Demonstrate the viability of prescriptive, preventive CMS-funded housing interventions and the innovative GHHI model to produce long term savings to payers and CMS;
- Develop a non-fee for service payment model incorporating asthma trigger reduction services and in-home education into the health care infrastructure in Maryland and Rhode Island

With the national average charge for an asthma hospitalization for children with Medicaid at more than $8,200 and a single ED visit averaging $820, the GHHI-AIM model can significantly decrease payer costs for unnecessary, high cost medical utilization. The program, which has received actuarial certification, is designed to save Medicaid $ **952,645.40** in three award years and **$5,147,505.60** in additional anticipated savings in the subsequent two years.

GHHI and its partners will implement comprehensive reporting and evaluation measures to inform program activities and CMS in quarterly reports. Measures will be designed to inform across the areas of cost savings, clinical outcomes, quality of care delivered and patient satisfaction, as well as process measures of program activities. Through existing and anticipated expanded involvement in health care innovation activities in both locations, GHHI will also use results to inform model integration into the health care delivery system beyond immediate partners. In addition, GHHI currently partners with 17 locations nationally and more than 60 other cities have requested inclusion in the initiative, further enabling an easily scalable and rapidly deployable expansion of the model.

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DELIVERY OF CARE

A visit to the front lines of primary care delivery at Memorial

Training the next generation of caregivers in a patient-centric approach

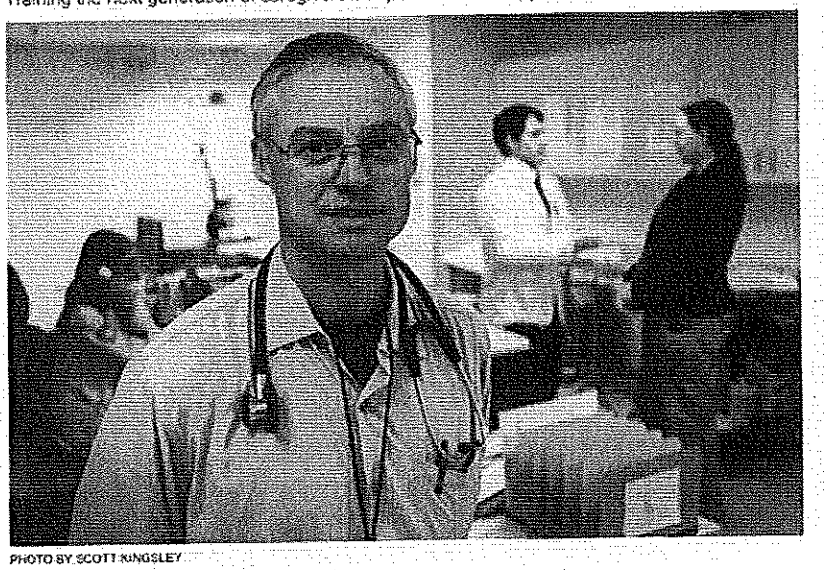

PHOTO BY SCOTT KINGSLEY

Dr. David Ashley, medical director of the Family Care Center at Memorial Hospital, believes that primary care needs to look for the root causes of health problems.

By Richard Asinof
Posted 11/4/13

WHY IS THIS STORY IMPORTANT?
The transformation of health care from a hospital-centric to patient-centric primary care model is moving ahead rapidly in Rhode Island, and Memorial Hospital is the training ground where new doctors are learning the model. Combined with the

PAWTUCKET – When Brown University re-established its medical school in the 1960s, with the hospitals as the driver, pushing a reluctant Brown to do so, there was duchy system, with each of the hospitals receiving one or more departments as a prize, according to Dr. Jeffrey M. Borkan, physician in chief of the Department of Family Medicine at Memorial Hospital of Rhode Island, now part of the Care New England hospital network.

"Family medicine was given to Memorial," Borkan said, in part because of its connection the community

Over the next 40 years, Borkan continued, as the development of specialties

network of community health centers, the new model is as much about changing health care from treating illnesses to promoting good health.

THE QUESTION THAT NEEDS TO BE ASKED

The successful growth of patient-centered medical homes will not only promote changes in the business model of hospitals, it also will force pharmacies to change their models of services, too. Why has CVS Caremark decided to launch a series of 'Minute Clinics' in Rhode Island, which detractors say is an attempt to undercut the patient-centered medical home model?

UNDER THE RADAR SCREEN

The integration of behavioral health within the practice of primary care is still an iterative work in progress, very much a learning process. A team approach – where social workers, psychologists, nurse managers and clinicians actively consult with each other -- is one way that Rhode Island can begin to address the soaring demand for behavioral health services.

grew in Rhode Island, Memorial was very much the place that kept the flame alive for primary care in Rhode Island.

"The metaphor I like to use is that [Memorial] was like a monastery during the Dark Ages, even if primary care wasn't popular, the flame was kept alive," Borkan told ConvergenceRI in a recent interview in his office. "Now, it's like the Renaissance here, we're able to expand into a system of care. And Care New England is interested in creating a system of care, not a group of hospitals."

The deal to partner with Care New England closed on Sept. 2, and Borkan voiced enthusiasm for the change. "We're thrilled to be part of Care New England."

Today, Memorial is very much at the center of the health care evolution in patient-centric primary care in Rhode Island, serving as a teaching laboratory to develop innovative approaches to team-based care. Until recently, Borkan said, "I don't think primary care was seen consistently as an economic advantage. But it is now."

The expansion of the multi-payer R.I. Chronic Care Sustainability Initiative, which began as a pilot program and now has more than 250,000 patients – one quarter of state's population – being served by practices that are patient-centered medical homes, places Rhode Island ahead of the curve in innovative health care delivery, according to Borkan.

When Memorial's Family Medicine program first sought to become part of CSI-RI, there was at first some hesitation. Borkan said he countered the resistance by arguing the importance of training the next generation of doctors in new models of care.

"We don't have, as a training site, the option of not being part of innovation and creating new models," he explained. "We are responsible for the next generation of doctors, and if we don't innovate here and begin to teach new models and be on the cutting edge of developing new models, then our graduates will not know how to practice in the new marketplace."

A recent visit from a federal evaluator of the CSI-RI program provided some national perspective of how advanced Rhode Island is in its patient-centered medical home approach to primary care.

"We're going from a small pilot to 25 percent with plans to go to 50 percent [of the state's population]," Borkan said. "No other state is doing that. This is a huge breakthrough in what we're doing here."

The actual transformation of medical practices to patient-centered medical homes is not something that is easily accomplished, because each practice is different, according to Borkan. "There is not yet a gold standard or a recipe of how to do it," he told ConvergenceRI. "At this point, expertise is being developed in the state in two places, here at Memorial and at Blue Cross & Blue Shield of Rhode Island."

Memorial is working with CSI-RI to help transform new practices that join the initiative, mentoring the practices, Borkan continued. "It's incredibly complicated and phenomenally difficult, because every practice is different and has its own dynamics."

At some point, Borkan said, Rhode Island's growing expertise in team practice may prove to be a marketable enterprise and a revenue source for Memorial – and for Rhode Island.

"Patient-centered medical homes are one piece of the puzzle," Borkan said. "We have to go from patient-centered medical homes to patient-centered neighborhoods to Accountable Care Organizations. We have to involve specialists, hospitals, and nursing homes. As part of Care New England, we can actually do that. Eventually, it has to be all of Rhode Island, and all of the U.S."

On the front lines of primary care, seeking out root causes

Dr. David Ashley, the medical director of Memorial's Family Care Center, rattles off the numbers as he gives ConvergenceRI an impromptu tour of Center's facilities. "There are about 10,000 patients, with some 39 residents, divided into three pods," he said.

Ashley, who did his residency at Memorial, graduating from Brown Medical School in 1996, has been back working at the hospital for a little more than two years. He sees the work of the Family Care Center as

changing the way that medicine is being practiced, looking at the root causes of problems, and not just treating illnesses.

"We want to keep people healthy," Ashley said. "If we an get to the root causes of things, whether it's bat poop in the belfry of someone's house that's [triggering asthma] and causing them to miss school and have multiple ER visits, then that's the dimension we have to address."

Ashley is currently collaborating with the Green & Healthy Homes Initiative to write a grant proposal to the Center for Medicaid & Medicare Innovation for a pilot project in Pawtucket and Central Falls to rehabilitate homes.

"They used to think that the root cause of asthma was asthma, and you treat that by taking your medicine," he continued. "But if we can get to the source of problems, and not just with asthma, we can improve people's health and save kejillions."

The incentives for payments will totally change, Ashley continued, if progress continues to evolve with the development of Accountable Care Organizations.

One of the expansions now underway with the CSI-RI program is CSI-Kids, which is currently struggling with developing benchmarks for wellness for children. Did Ashley have a suggestion of what the metrics might be?

"I think if there was only one thing you could measure for kids and try to figure out the best way to invest your resources, it would probably be school absenteeism," he said.

With primary care, Ashley continued, "You can't leave the social and financial conditions out of the equation. School absenteeism is often a very early indicator for problems in life. We need to investigate the reason for those absences, to find out if there are problems at home, with transportation, with health."

One of the frustrations for Ashley is the inaccessibility of data regarding the most expensive patients, data that the CEO of Neighborhood Health Plan of Rhode Island told Ashley he has but cannot share, for legal reasons. According to Ashley, the CEO said that he had the data of who the most expensive [Memorial] patients were, what their addresses were, and how much money has been spent on them in the last two years

"if we can't identify the patients, we can't assign the nurse care managers to better manage these patients," Ashley said. He said that one of his folks had called Medicaid in Rhode Island to ask for this data, and was told by whomever answered the phone that they would need to file a Freedom of Information Act request to do so.

Ashley said that if a legal way could be found to access this data from Neighborhood Health plan, it would help to better manage the most expensive patients, reducing costs, improving outcomes and help prove that patient-centered medical homes work. He acknowledged that some interventions would not work.

[While the Family Care Center has about 3,000 of its roughly 10,000 patents who have enrolled to be part of thre stat's health information exchange, Currenicare, it has been unable to send any continuity of care documents because of computer interface issues, according to Ashley.]

For Ashley, the new approach to patient-centric family is a much more satisfying way to practice medicine. Here in Rhode Island, Ashley continued, "The visionaries are in the right places. We got a great director of the R.I. Department of Health in Dr. Michael Fine. He gets it. And with Care New England, the CEO, Dennis Keefe, he gets it, he knows it, he's pushing for it."

Ashley's fear, he continued, "is that it is an experiment that may continue, because it's going to be more expensive than just having an office and a doc and a secretary."

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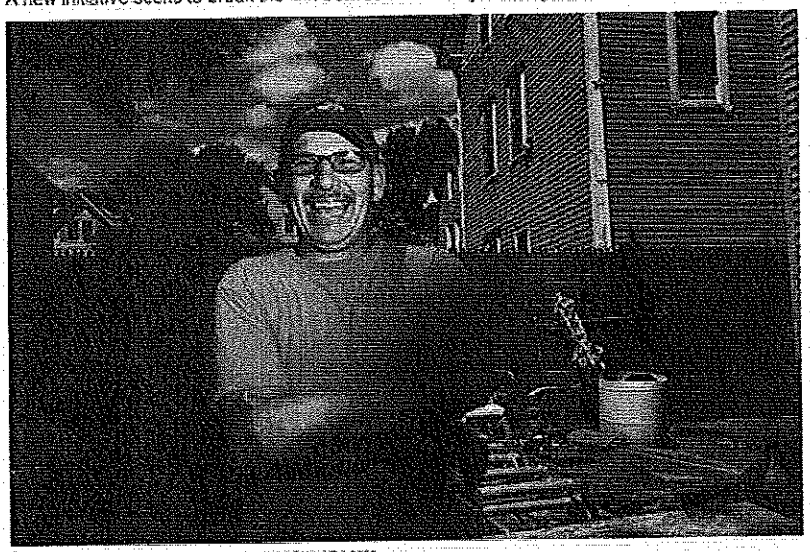
IN YOUR NEIGHBORHOOD

Good health begins at the front door of where you live

A new initiative seeks to break the link between unhealthy housing and unhealthy children



COURTESY OF MARK KRAVATZ, STUDENT INTERNS AT AS220

A contractor who was part of the Green & Healthy Homes Initiative in Providence, which renovated 135 homes in Providence last year.

PHOTO 1 2 3

By Richard Asinof
Posted 10/28/13

WHY IS THIS STORY IMPORTANT?
Investments in the best health care technology and IT infrastructure will not

PROVIDENCE - What a week it was for high profile, top-down, show-and-tell public relations events touting multi-million-dollar investments in infrastructure to support the knowledge economy and its innovation ecosystem in Rhode Island.

translate into effective health care delivery unless the underlying causes are addressed – the preventable, man-made environmental and health threats that sicken many of Rhode Island's children. Asthma is a leading cause of missed school time, lead is a major cause of poor academic performance. Their prevalence drives medical costs up and educational potential down. It's a huge economic issue. The R.I. Alliance for Healthy Homes seeks to leverage existing resources by aligning and braiding them in a comprehensive effort to focus on community solutions.

THE QUESTIONS THAT NEED TO BE ASKED

The absence of the R.I. Department of Education as a partner in this effort appears to be a problem, one that could be solved. What will it take for Commissioner Gist and R.I. Board of Education Chair Eva-Marie Mancuso to begin to address the chronic problems of lead poisoning and asthma in our schools? Health insurers are spending enormous advertising budgets to sign up new customers. Why have Blue Cross, Neighborhood, and United failed to cover asthma home visits as a reimbursable expense, even though their own data shows the prevalence of expensive interventions?

UNDER THE RADAR SCREEN

The business community has paid much attention recently to wellness programs in the workplace, promoting employee programs to increase healthy outcomes – and achieve cost savings in reducing their health insurance costs. What will motivate them to pay similar attention to wellness programs for the communities in Rhode Island? Perhaps there is a need for a new app that will calculate the direct cost of "externalities" of poorly maintained housing stock for the real estate and banking sectors.

On Tuesday, Oct. 22, the 195 Commission hosted a hardhat tour of the 20 acres of land being reclaimed after the relocation of Route 195, showcasing the work being done "underground" on connections and conduits for electric, gas, water, and fiber utilities.

On Friday, Oct. 25, Rhode Island's entire congressional delegation as well as Gov. Lincoln D. Chafee hooked up for a press conference at the Providence Public Library to celebrate the completion of Beacon 2.0, the build-out of 400 miles of fiber-optic cyber infrastructure connecting 150 anchor institutions, including universities, hospitals, research centers, libraries and K-12 schools.

Later that afternoon, Sen. Jack Reed was joined by U.S. EPA Director Gina McCarthy and Providence Mayor Angel Taveras to announce the environmental agency's support for design and construction of up to four projects in the Providence metro area to showcase what's known as "green infrastructure" to help protect Narragansett Bay and local streams and rivers from dirty water and raw sewage overflow caused by heavy rainfalls.

Earlier in the week, Reed's office had announced an additional $6 million in funding from the U.S. Department of the Interior to help Rhode Island with restoration projects to help the state prepared for future storms such as Hurricane Sandy.

Recognizing the value of human infrastructure

Yet, the low-key, bottom-up launch of the Rhode Island Alliance for Healthy Homes at a community forum at Rhode Island College on Oct. 22 may prove to be the most impressive – and innovative – "infrastructure" investment announced last week in Rhode Island. More than 100 people crowded into the lecture room at Alger Hall, participating in small breakout sessions.

The new alliance's mission is to "align, braid and coordinate" the resources of an evidence-based approach to public health with community-based energy and housing initiatives. (It was the kind of community-focused innovative approach that was "missing" from the draft State Health Innovation Plan released last week.)

The alliance is a collaborative partnership of the R.I. Department of Health, the R.I. Office of Energy Resources, the R.I. Department of Human Services, the R.I. Housing Resources Commission, Rhode Island Housing, and the Green & Healthy Homes Initiative.

The driving force behind the new alliance is Mark Kravatz, who is coordinating the initiative. He works for the Green & Healthy Homes Initiative, headquartered in Baltimore, Md., and he directed a pilot program in Providence during the last year that renovated 135 homes in the Olneyville section of Providence.

"Our work is data-based," Kravatz told ConvergenceRI in an interview following the forum. "For the 135 homes we [renovated] in Providence, we were looking at key deliverables for that work – showing a reduction in hospital visits for asthma, reducing the energy usage, reducing the chronic absenteeism in school due to asthma, and improving the health and safety of the homes."

Saving money, Kravatz continued, is an important economic piece of this work. For children with asthma, who repeatedly need treatment at the emergency room, spending a lot of money, getting prescriptions for an asthma inhaler, only to be sent back to homes where there may be many asthma triggers, which cause a repeat the cycle, drives up medical costs. "Our goal is to reduce those triggers in [the children's] homes," he said, saving money for the parents – and for the health care delivery system.

Kravatz called himself an "outcome broker," saying that his job "is to broker multiple on- the-ground resources to work more collectively."

As much as Kravatz serves as the project coordinator, he is quick to

emphasize the team approach. The Alliance's steering committee includes:
- Bob Vanderslice, from the R.I. Department of Health's Healthy Homes program,
- Nancy Sutton, from the R.I. Department of Health's Asthma Program,
- Michelle Almeida, from the R.I. Department of Health's Healthy Homes program
- Marion Gold, from the R.I. Office of Energy Resources,
- Rachel Sholly, form the R.I. Office of Energy Resources,
- Mike Tondra, from the R.I. Housing Resources Commission,
- Darlene Price, from the R.I. Housing Resources Commission,
- Greg Schultz from the R.I. Office of the Attorney General,
- Julie Capobianco from the R.I. Department of Human Services' Weatherization Assistance Program, and
- Russ Johnson from R.I. Housing.

Health care and asthma

One of the documents distributed at the community forum was a series of maps and charts breaking down the statistics for immunization, asthma and lead poisoning by school districts in Providence and statewide.

In particular, the chart, "Health care utilization due to Asthma, 2010 -2012," painted an accurate but grim picture of the number of school children afflicted with asthma in Providence – and statewide.

In Providence, 17.9 percent of all schoolchildren in pre-kindergarten through Grade 5 – 2,253 out of 12,799 – had asthma. In total, looking at children through Grade 12, 14.5 percent of all students suffered from asthma and required medical attention. Statewide, the numbers are almost as bad – 11.8 percent.

The numbers are evidence-based. They come directly from the health insurers – Blue Cross & Blue Shield of Rhode Island, United Healthcare of New England, and Neighborhood Health Plan of Rhode Island.

Specifically, "children with asthma" was defined as children who were insured by one of these plans and had any doctor's office visit when asthma was one of the top reasons for the visit or an emergency room visit or hospitalization when asthma was the primary.

Perhaps the most damning statistic was the high number – 14 percent, or 511 out of the 3,649 children with asthma – who ended up at the emergency room or who were hospitalized.

Nancy Sutton praised the efforts of Kravatz in bringing together so many people in the alliance – physicians, contractors, city and town officials – with a common interest in healthy housing.

"Within state agencies, we all have our own procedures and funding streams," Sutton said, explaining the importance of the effort. The effort to have all these agencies aligned and on the same page, working toward healthy housing, is a relatively new concept, one that she is excited about.

Since 2010, the Asthma Program has developed a evidence-based approach and home visitation focused primarily on children living in the city of Providence, Sutton said.

Working in partnership with Hasbro Children's Hospital and St. Joseph's Hospital Health Clinic, Sutton continued, when a child is seen by the emergency department and the diagnosis is asthma and they live in Providence, they automatically get a referral for a home visit.

With parental approval, a certified asthma educator, a community health worker and an environmental health worker visit the home, working with the home owner or landlord to fix and address any issues.

The program has been able to expand its efforts through a 2011 federal innovation grant from the Center for Medicare & Medicaid Innovation. Despite the program's expansion, what Sutton calls the biggest obstacle is that the commercial insurers don't cover the asthma home health visits as a reimbursable expense, despite the documentation from their own data about the incidence and prevalence of asthma – and the high cost of treating asthma through emergency room visits and hospitalization.

From the data collected over the last three years, based on health insurance claims, Sutton's program has been able to prepare a fairly comprehensive map of where asthma is most prevalent in Rhode Island. [See graphic] Not surprisingly, the heaviest concentrations are in the state's core urban areas, with the oldest housing stock.

"We don't know exactly what causes asthma," Sutton said. "Not one thing causes asthma." But, she added, "We know what can contribute to making asthma worse – mold, mildew, second-hand smoke, air pollution." And, preliminary data from the asthma program has shown that home visits and interventions have cut down on the number of emergency room visits and hospitalizations.

"We've seen significant reductions in night-time symptoms," Sutton said. "We've seen significant

improvement in sick visits to primary care providers." And, according to self-reported data, Sutton continued, "there has been a drop in the use of emergency rooms due to asthma."

Connecting the dots, leveraging resources

If you look at the composite map detailing the incidence of lead exposure, asthma, childhood poverty and older housing that was distributed at the R.I. Alliance for Healthy Homes forum, it's no secret where the problems are located.

What's been missing in the past is a coordinated effort to develop a community-based solution, leveraging existing resources. The R.I. Alliance for Healthy Homes is the kind of smart collaborative approach that many business and government leaders advocate but never implement.

Kravatz said that conversations are now underway with the primary care physicians at Memorial Hospital to enable them to write health and safety prescriptions as part of a model pilot program serving the residents of Central Falls and Pawtucket, to conduct health safety audits.

Related

Explaining the Green & Healthy Homes pilot project in Providence

UnitedHealthcare
A UnitedHealth Group Company

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November 26, 2013

Office of Lt. Governor
State House Room 116
Providence, RI 02903
ATTN: Public Comments

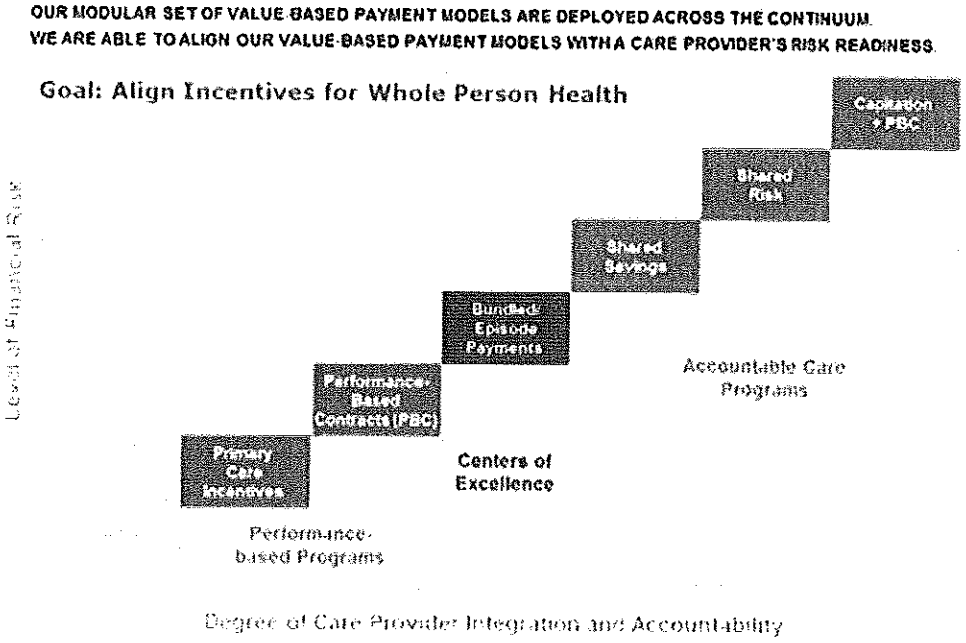
Dear Lt. Governor Roberts:

UnitedHealthcare appreciates the opportunity to have participated in the workgroups in connection with the Rhode Island's State Healthcare Innovation Plan and would like to take this opportunity to provide our support and comments on the draft plan. UnitedHealthcare is committed to the development and testing of new integrated models of care, effective payment reform, quality improvement and encouraging practice transformation. Nationally and locally, we have made substantial investments in medical home and accountable care models and other value based incentive programs. We have direct experience in contributing resources to provider practices that have demonstrated a commitment to transforming these into high value, efficient primary care setting that employ care teams and practice population management. We fully understand that partnership is required during the design and development of Rhode Island's Healthcare Innovation Plan and look forward to further engagement with Rhode Island in this effort. Furthermore, we would like to propose a meeting to discuss certain aspects of the plan, such as potential duplication of services, funding, interactions with existing models and the structure and functions of RICTIC.

TARGETS FOR TRANSITION TO VALUE BASED CARE

The State has asked for comments on targets for transition to value based care and how it can be phased in over a 5-year target period. Practice transformation takes time. Providers need to be rewarded based on their readiness and capabilities. Stakeholders need the ability to develop a suite of value-based contracts that complement and assist providers as they move across the continuum of risk. Provider readiness is individual. We cannot expect every provider to move along the continuum at the same rate or attain the highest level in a pre-defined period of time. For payment reform to be successful we must account for varying levels of risk and integration and develop programs that encourage movement along the continuum at varying rates. It is also important to consider the standardization of certain quality and outcome measures along with how these are ultimately operationalized in the service delivery system. These quality and outcome measures are the basis for any payment reform strategy. Payment reform methodology and roll-out will be

important to consider as it is important that free market dynamics are tested and developed. In other markets we have deployed a continuum of options to support movement to value based care:



We would like to further consider the impact to the market if the state as a payer mandates ACO like structures for pre-defined populations. We believe reform will be more successful if the initiatives encourage providers to deliver high-quality care more efficiently, with a specified mix of strong performance incentives that reflect the market structure and capabilities of the local community. Mandating ACO like structures may accelerate unintended provider consolidation, impact pricing and market choices. In addition regulatory changes focused on benefit design that encourages but doesn't support members staying within a defined network may dilute the desired quality outcomes and the savings impact of ACOs. The proposed plan is encouraging significant market changes and the market needs to have multiple tools available to implement and evaluate changes.

In considering Medicaid managed care transitioning to ACOs, the current managed care contracts and risk sharing arrangements between the State and the Medicaid health plans do not easily permit sharing of risk with a provider organization. To effectively implement ACOs in the Medicaid space, the State would need to reevaluate its risk sharing requirements and possibly eliminate them. UnitedHealthcare is also unclear how the ACO would be implemented with the Federally Qualified Health Centers (FQHCs) who are the primary care managers of a significant portion of the Medicaid population. We would ask the State to share their thoughts as the FQHCs are a key driver of quality and cost outcomes for the Medicaid program.

CARE TRANSFORMATION AND INNOVATION CENTER

The proposal introduces the concept of developing an entity, Rhode Island Care Transformation and Innovation Center (RICTIC) to provide assistance and support to stakeholders during the next 5 years. Given the majority of solo, 2, & 3 physician practices as opposed to large medical group in the state, to transition 80% of the state's population to value based payment and ultimately global risk, many of these small practices will need significant assistance and resources to transform themselves.

COMMUNITY HEALTH TEAMS

United Healthcare supports the use of Community based care teams that promote transparency and collaboration in the care and treatment of the patient. United Healthcare has taken a leadership position in many markets with the successful deployment of innovative clinical engagement strategies that accompany financial incentive strategies. These strategies leverage technology and engagement with physician practices to reduce fragmentation of care and the resulting cost that burden the system.

The State has identified care transitions as a challenge; historically inadequate care transitions are costly with poor health outcomes. A component of the proposed solution is the expansion of Community Health Teams (CHT). To better evaluate the use of CHT in Rhode Island we need to understand the specifics of how the population for this program will be defined and engaged. We see the value of CHTs working with hospitals, providers and MCOs in health education programs, residential visits, nurse and social worker interventions, drug programs and other programs already in use for these patients. CHT teams should leverage and not duplicate services available in the community currently.

One possible model would be to align the CHT's with practices so that we are not creating separate entities. The funding of CHT's must be aligned with clinical and quality outcomes as well as medical cost savings. The CHT teams need to be aligned with the providers who are closest to the patients and so that they have joint accountability for quality, clinical and medical outcomes. Workforce development, training and oversight of these teams is a key component.

POPULATION HEALTH TARGETS

The plan does not lay out sufficient details on how the current CSI and various CMS models already in place in the market will interact with expansion of value-based structures outlined in this proposal. Without a clearly articulated approach, there is a risk of duplication of resources and efforts as well as a risk of conflicting goals undermining each initiative.

While the goal to improve primary care is a worthy one, it's important to step back and apply lessons learned from the current CSI program. UnitedHealthcare's experience recommends the following considerations:

- Requiring additional guaranteed fee payments to primary care providers risks creating an unintended consequence of higher inflation in total cost of care

- Incentives and payments ought to be structured so that providers are held accountable for transformation to achieve higher quality, more efficient care

BEHAVIORAL HEALTH STRATEGIES

Co-location of Primary Care and Behavioral Healthcare is a strong principle that has merit in transforming our care system and has shown positive member outcomes in our experience. The focus on FQHCs and Community Health Centers may create some financial challenges that need to be addressed. Transition of services from BHDDH to EOHHS and the Medicaid managed care organizations as part of Medicaid Expansion and the Integrated Care Initiative is an initial step in better coordinating medical and behavioral care, co-location or virtual co-location is a possible next step.

Thank you for the opportunity to review and comment on the Rhode Island's State Healthcare Innovation Plan. We look forward to continuing to work with you throughout this process, and greatly appreciate the opportunity to continue our dialogue.

Sincerely,

Stephen J. Farrell
Chief Executive Officer

Patrice E. Cooper

Patrice E. Cooper
Executive Director
Rhode Island Community Plan

Rhode Island State Healthcare Innovation Plan

Rhode Island Department of Health Public Comments

These comments are made in the spirit of a process that has been open and positive throughout, for which the Rhode Island Department of Health is most grateful.

The Rhode Island State Healthcare Innovation Plan (SHIP) draft has been developed in a context which challenges everyone's ingenuity, and is precipitated by the continuing escalation of the cost of medical care beyond both the rate of inflation and the growth of gross domestic product. This cost trend cannot long be sustained, yet will persist both despite and because of the workings of the Patient Protection and Affordable Care Act (ACA).

The parameters set by the terms of the grant, by its funding scale and by the need to successfully compete with other states' proposals can argue for a practical approach. While this practical reality is acknowledged, we also urge that the unique opportunity to pilot, test and establish genuine innovation offered by this grant be maximized.

The Rhode Island Department of Health's (HEALTH) recommendations focus on five pillars: governance; achievable and meaningful cost control goals; mental/behavioral health and substance abuse; public health goals and objectives, and support of the primary care delivery system.

I Governance

The process of creating adequate accountability requires a central governance structure. We advise caution in assuming that providers can or should be held accountable for the health of an attributed population (SHIP draft page 38) – at least until there exist large vertically integrated provider and risk bearing organizations that have an infrastructure that is robust enough to managed that care.

Rhode Island is very far from having organizations of that size, and from the perspective of critical mass likely lacks the population size to support even one such organization. But even supposing we could support one or two such organizations, they are unlikely to evolve within the three year period of the grant.

Rhode Island's providers already work diligently to maintain service quality for the services they do provide. Until large vertically organized organizations evolve or move

here from other states, we should better develop a process to determine what outcomes we wish to achieve, what services are necessary (given our existing health status and demographics to achieve those outcomes), and what prices we are willing and able to pay for those services. Then we can institute oversight of those services, their quality, and their costs, to ensure that the services we decide to purchase are provided as promised, and to ensure that those services create the health outcomes projected.

Additional analysis of service delivery planning will strengthen the confidence level of the projections outlined in the SHIP Financial Overview document. The Advisory Board Company has clearly described the market's perception of the absence of clear command and control in state government vis-à-vis the health care sector, which will remain a challenge going forward

II Rising Costs and Sustainability

The actuarial consultants estimate that the SHIP will realize cost savings over three years of: Medicaid 5.5 percent; Medicare 3.5 percent; Commercial 3.0 percent for an aggregate saving rate of 3.8 percent compared to the current cost inflation trend. While all the interventions can work as described, they must overcome some considerable challenges to achieve the necessary rate of scalability.

To measure cost savings, the SHIP could be strengthened by adding a comparison to current cost savings to the analysis. Since it is projected that real costs will go up despite savings (approximately 4 to 6 percent, given a certain degree of predictive variation in the ACA newly insured population), it will be useful going forward to have this additional way to track success and challenges

The SHIP can also be strengthened with a view that encompasses delivery system changes in surrounding states, and the impact those delivery system changes are likely to have on the Rhode Island health services delivery system and on the Rhode Island economy. The anticipated strengthening of hospital infrastructures in surrounding states, (and the lead that those systems have in developing vertically integrated systems of care compared to Rhode Island), is very likely to result is a strong entrance of one or more of those systems into the Rhode Island market. The SHIP should take cognizance of the potential effects of such a development, for example on Rhode Island jobs in health care management and tertiary care, and on state and local capacity to influence our own health services delivery system.

The challenge for Rhode Island is to drive down our costs more quickly than surrounding states. By doing so are we going to be able to rebuild our economy and protect local control of health services decision making, understanding that a strong and equitable economy is likely the most significant predictor of positive public health outcomes.

HEALTH recommends that considerations regarding cost savings focus on four challenges: self insured employers, mental and behavioral health; broader utilization of CSI; and the primary care avoidant population.

Self-insured employers: represent 43 percent of the commercial market. The SHIP should define a methodology to include them in a multipayer process to help reach the challenging goal of including 80 percent of Rhode Islanders in value-based care arrangements. HEALTH has assembled a multiple agency working group that includes representation from the General Assembly and the Governor's Office to find a solution to this challenge. We strongly suggest that some of the grant funds be used to address this issue.

Mental / Behavioral Health and Substance Abuse. The costs associated with mental/behavioral health and substance abuse strongly indicate that these issues must be addressed vigorously. The co-location of mental health providers with primary care practices, independent of other integration reforms, has been proven to be a limited strategy. There is good integration science, and the best findings show that only capitating practices to provide both primary care and mental health is likely to be effective. Integration in and of itself is also a limited approach for substance abuse treatment; a more concrete and comprehensive strategy than that detailed here would be well-taken.. Reforms that could be considered include: recovery centers in every community; multidisciplinary non-narcotic chronic pain treatment centers; emergency department (ED) diversion to substance abuse treatment centers; highly developed medical assisted therapy options; and robust inpatient hospitalization and treatment for patients who are substance addicted, and who require special skills for their medical management and mental health issues.

The Broader Utilization of CSI. The descriptive information (but not the financial model) places considerable emphasis on the spread of the patient centered medical home (PCMH) model and of CSI. While this can represent a step forward, we caution against overdependence on the PCHM model as a basis for cost control. The original practices were early adopters and were the most likely to become proficient at population health management. There remains considerable room for improvement and growth in those practices in terms of population health management and treatment to goal. The remaining practices that have not adopted PCMH are unlikely to do so, or are less likely to become as adept at population health management.

Primary Care Resistance. At least 12 percent, but perhaps as many as 30 percent, of the population is primary care resistant (individuals who have health insurance but don't use primary care for the bulk of health services). This population, who don't want to become activated patients, together with 50,000 or more of the remaining uninsured (based on projections from HealthSourceRI), will continue to drive cost and increase morbidity. The SHIP could be strengthened by that addressing this key population. Recognizing the importance

of this factor, health policy experts as diverse as David Satcher, Paul Grundy, and Kurt Stange have become supporters of the Primary Care Trust, which is designed to achieve the goal of primary care for the whole population, and is why Tom Bodenheimer has written extensively on the limitations of PCMH.

III Mental/Behavioral Health and Substance Abuse

As stated above (as shown on the graph on SHIP draft page 32), many of our cost and outcome challenges involve mental and behavioral health, and substance abuse. It is important to recognize that the single most significant contributor to years of preventable life lost in Rhode Island is prescription drug overdose death (note, however, that IV drug overdose death appears to have recently eclipsed prescription drug overdose death in the near term). The innovation proposed – the co-location of mental and behavioral health and primary care – has been tried repeatedly, and its limitations are well known. It is key to institute a full methodology to address substance abuse treatment issues, perhaps the single greatest health care challenge we face. The SHIP could be significantly strengthened by incorporating additional mental/behavioral health and substance abuse treatment infrastructure proposals.

IV Public Health Goals and Objectives

The section on Healthcare Goals (SHIP draft page 35 et seq.) conflates goals, strategies and tactics; quality with outcome; and healthcare with health. The section replaces an epidemiologically driven and precise goal-setting process now run by HEALTH with the many) goals in Healthy People 2020 and in the Center for Disease Control and Prevention's "A Million Hearts" initiative, while making reference to American's Health Rankings. As a result, it is difficult to analyze the overlapping and constituent indicators of each.

HEALTH notes that there is no evidence-based intervention to reduce preventable hospitalization within the draft. We believe that the reduction of preventable hospitalization requires a multipronged approach, and should include changes in provider behavior, improved primary care access, and regulatory changes.

HEALTH's approach to measure goals and objectives uses instead a consideration of Years of Potential Life Lost. We also intend to use Per Member Per Month (PMPM) cost; Days of Lost Work and School, and Indicators of Social Capital when good indices for the latter three measures become available. We have a particular focus on eliminating health disparities on the basis of race, culture, language and physical ability, a focus entirely absent from the SHIP proposal.

We have recently turned our attention to three indicators from American's Health Rankings, but have not yet set targets for these three: preventable hospitalization, binge drinking, and sedentary life style. A further selected list of leading health indicators that should be reviewed, but which do not yet have Rhode Island targets are in the notes. [1]

The SHIP would be strengthened by addressing a precise methodology to achieve public health goals. It does not specify or fund the use of the quality assurance process in primary care practices, a particularly promising intervention which should be supported by the grant.

V Support of the Primary Care Delivery System

Although the Financial Overview does not detail the funding methodology for extra community services, like Community Health Teams (CHT), the dollar amount suggested in presentations about the financial model was $12 PMPM. That number, which is very close to the current full spend on primary care in Rhode Island, would be used to create another service delivery model, and create more complexity in an already overcomplicated delivery system array of market actors. More importantly, this innovation diverts funds that could be used to directly support primary care practices.

In the last twenty years, primary care practices have lost income once earned form attending patients in the hospital. They have lost income as immunizations have move to mass immunizers and pharmacies. They have lost income form urgent care. They have lost income from the provision of laboratory services. They are likely to lose volume and income from routine sick visits, as retail pharmacy clinics gin a foothold in Rhode Island. They have lost income to electronic medical record (EMR) providers while we made their practices and lives endlessly complex by requiring EMR use.

HEALTH suggests that resources such as those earmarked for CHTs are better targeted to strengthen primary care and authority structure.

Additional Comments:

The Definition of "health"

Applying the World Health Organization's definition of health, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" in the draft SHIP proposal sets a standard which fundamentally undermines the ability to measure success in achieving public policy objectives. The definition was adopted in 1946 [2] and is not a measurable standard. While its breadth seems to accommodate setting goals that encompass social, behavioral and environmental determinants of health, the ideal of "complete," and the lack of measurable criteria invites an unfocused implementation of the plan, and a lost opportunity to fully measure success or adequately measure progress.

A definition of health that has achieved some attention in the health policy community and is measurable is: "health is the biological, social, and psychological ability that affords an equal opportunity for each individual to function in the relationships

appropriate to his or her cultural context at any point in the life cycle and/or the equal ability to participate in the democratic process." [3] (Other similar definitions are reviewed in Stange, K. Power to advocate for health. Ann. Fam. Med. 2010 March; 8(2): 100–107).

The SHIP draft would be strengthened with a refined definition of "health." Distinctions between individual health, public health, relief of pain, fulfillment of personal desires or goals, and life extension are often conflated and otherwise confused in the public mind, In order for the public and private payers alike to best target scarce resources, we need a definition that allows us to purchase services in the public interest – services that allow individuals to function in the marketplace and in the democratic process as effective agents of their own self interest. An inadequate definition will continue to enable market dynamics that create profit at public expense by selling health care goods and services to improve an entirely subjective sense of well being. We can no longer afford this kind of health care environment.

Multi-Payer Model and Costs

Broadly defined, the various initiatives in the SHIP advance the practice of managed care. While these latest iterations of managed care can and will do a better job of managing actual care and not just costs, we are at the point where the cost tread will produce an access crisis. In this light, care itself, and not just well managed, high value care, can be seen as the fundamental issue to address. Substantially reducing administrative costs -- which are currently over 30 percent -- should be an integral part of at least one pilot innovation. After all, administrative costs add little or no value to the health care system, whether value is measured in patient care or in patient outcomes. That is certainly true of unnecessary administrative costs. The Primary Care Trust is an innovation that would aggregate monies already in the system, simplifying and streamlining claims processing and billing procedures alike, and should be supported by the grant.

Health Information Exchange and CurrentCare

The SHIP proposes to allocate grant monies to the expansion of CurrentCare. The goal of a more extensive and therefore robust information exchange is well taken; both private medical practice and public health can and will benefit from a robust HIE. But the draft fails to address the key impediment to achieving significant enrollment expansion in an expeditious manner. A model well tested in other states (that would be an innovation if adopted in Rhode Island) is an Opt-Out system. Resources to convert from our Opt-In model should be part of the funding request.

Community Health Teams

Community Health Teams have been tested in places such as Vermont where the population is less dense than Rhode Island's, but it's not clear whether these CHTs will be effective in an urban environment. As discussed above, CHTs will, however, divert considerable resources that could be used to build actual PCMHs that can function as public health engines.

Focused care-coordination of people at highest risk has been used effectively in places like Camden, New Jersey, but its use has not been integrated well into Patient Centered Medical Homes. It is not clear how a segregated approach to the highest risk will impact the primary care ecology.

Hospital System Failure

Approximately 40 percent of global medical costs are incurred by hospital care. The state has determined that Rhode Island has excess capacity of some 200 beds. It is also estimated that $100M per year could be saved if the excess capacity was trimmed through hospital closure. The SHIP draft, while projecting to achieve much of its savings by averting hospital utilization, could also incorporate a mechanism to achieve this additional path to cost savings.

Applied Savings

The SHIP proposes to accelerate the transfer of risk from payers to professional providers and to hospitals; but it is unclear exactly how the money, whether accounted for as an investment or as a saving, will be returned to the providers in a "reward system

Savings should be re-invested in two ways: to pay primary care practices to do QA/QI of public health educators, which we know will lead to improvements in public health. The second way is to spend the savings on education, housing, the environment, and public safety, all of which also have a positive impact on the public's health. It is only by redirecting medical resources to improve these factors that we can possibly achieve the better outcomes for less money that obtain in other countries around the world.

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[1] **Selected Healthy People 2020 Health Indicators**

Access to Health Services

Increase the proportion of persons with a usual primary care provider (AHS-3)

Baseline (US): 76.3 percent of persons had a usual primary care provider in 2007
Target (US): 83.9%

Nutrition, Physical Activity, and Obesity

Reduce the proportion of adults who are obese (NWS-9)

Baseline (US): 33.9 percent of persons aged 20 years and older were obese in 2005–08 (age adjusted to the year 2000 standard population)
Target (US): 30.5 percent

Reduce the proportion of children and adolescents aged 2 to 19 who are considered obese (NWS-10.4)

Baseline (US): 16.1 percent of children and adolescents aged 2 to 19 years were considered obese in 2005–08.
Target (US): 14.5 percent

Tobacco

Reduce cigarette smoking by adults (TU-1.1)

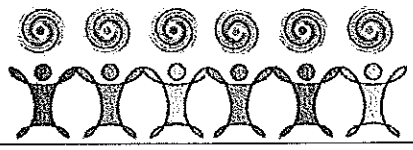
Baseline (US): 20.6 percent of adults aged 18 years and older were current cigarette smokers in 2008 (age adjusted to the year 2000 standard population)
Target: 12.0 percent

Reduce the use of cigarettes by adolescents (past month) (TU-2.2)

Baseline (US): 19.5 percent of adolescents in grades 9 through 12 smoked cigarettes in the past 30 days in 2009.
Target (US): 16.0 percent

[2] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[3] The Nature of Health, Fine and Peters, Radcliffe Publishers, 2007.



COMMUNITY HEALTH INNOVATIONS OF RHODE ISLAND

26 November 2013

Dear Healthcare Reform Committee,

We at Community Health Innovations of Rhode Island (CHI-R), the State's leading Community Health Workers' program for community-centered workforce and leadership development, thank you for the opportunity to give comments on the draft State Health Care Innovation Plan (Plan). To start, CHI-RI is pleased that social determinants of health (SDH) takes a prominent role in the Plan. The articulation of SDH in the plan coincides well the newly formed Commission of Health Advocacy and Equity. This commission requires a cross-section of state agencies and community members to focus on the social determinants of health to better the health and well-being of the state. The specific focus of SDH in the Plan will also place Rhode Island to fully participate in the new national conversation on SDH from the American Public Health Association (APHA) to the Institute of Medicine (IOM); see *For The Public's Health* series of reports Dec 2011 to April 2012.

The fact is that no matter how good health care delivery may be without attention to the physical and social environment that may make people ill in the first place disserves us all. In spite of our state's decade and over better access to health insurance as compared to the rest of the nation, noted in the Plan, RI has not fared better than the rest of nation in ending or decreasing health disparities across socioeconomic and racial demographics. Considerable evidence that social and economic conditions, apart from access to and quality of medical care, which have undeniable importance, play a fundamental, powerful, and pervasive role in the health outcomes of preventable diseases. It is most likely that it is the social disparities in RI many of which are noted in the Plan that must be attended to if we are to improve our general health status. Thus the articulation of SDH in the Plan will allow greater recognition that health comes about from where we live, learn, work, and play. Our neighborhoods and communities are ultimately more important then our genetic code and is what we must also focus on to achieve better health outcomes in RI. This in the end should decrease costs and yield efficiency and prosperity. Thus the goal to focus on SDH sets Rhode Island on the path for a more integral understanding of health and that clinical care is only one part of how we take care of ourselves.

We were also very pleased that the draft Plan appropriately makes direct, and even more indirect, references to the value of Community Health Workers (CHWs) and their role in improving community health. Real-life examples and a significant amount of academic research indicate that the most effective way to address the social determinants of health (SDHs) is to empower and train local community members such as CHWs. These workers are then deployed by community-based organizations (CBOs) to provide information, educate people about healthy living, and improve access to care. Investing in What Works in America, an entity developed by such organizations at the Robert Wood Johnson Foundation, which created a special edition in Health Affairs on community development and health, places CHWs as one of the workforces to be developed to improve community health. In an Investing in What Works conference in Boston on Nov 8th many emphasized the need for leadership to originate from the community where the purpose and goals for development can best be developed. This is exactly what a community based community health workforce would do.

However, we were surprised to see the CHW workforce described being unclear as not having a recognized definition and profession and the need to require credentialing and licensure. First in terms of a definition, the CHW section of the APHA, which is the largest national group of CHWs and their allies, created a definition that is accepted by the APHA and used by the Federal Department of Labor in its description and course requirements of the creation of CHW apprenticeship programs. That definition is as follows:

A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Secondly, a report on the count and employer demand for the CHW workforce in Rhode Island was completed by the Department of Labor and Training in 2009. Rhode Island is not only the first state to do a demand survey from an employers perspective but DLT was a regional finalized for the 2010 product/service award presented by Workforce Investment Council for this survey report.

Community Health Workers were recognized as a profession by the U.S. Department of Labor (DOL) in January of 2009 after a national campaign with over 1000 letters sent to DOL; marking the largest campaign request ever for a Standard Occupational Code (SOC). They were designated an apprenticable workforce by DOL in July 2010. Our state of Rhode Island's DLT recognized the CHW profession in February of 2012. However, we must not confuse this profession as yet another form of clinical medicine. Please note that several states have opted not to pursue licensing, such as New York, because CHWs are not a clinical occupation and there is minimal risk of harm from "unlicensed practitioners." A standards question may be valid and an acknowledgment that a payer for professional services has the expectation and the right to an agreement on the qualifications of a CHW and of those services. That being said, uniform standards or credentials can and should be defined by the practitioners themselves (the CHWs), and they do not have to resemble the licensing requirements of other professions. A strong case can be made that the process of developing and assessing the skills of this profession must be different from those of other health-related professions because the work is fundamentally different. There are clear guidelines and recommendations on the core skills needed from the landmark study on community health worker in 1998 by Rosenthal, L and Wiggins, N, as well as, the DOL work process for the profession published in July of 2010.

Lastly, while CHI-RI is dedicated to the creation of Community Health Worker Teams, we encourage the development of CHWs as patient navigators too. In that role/function, they should not be restricted to remaining physically located in the clinical facility - the greatest value to all concerned is when they have the latitude to work with people wherever they are. CHWs in the clinical setting communicates that the healthcare institution is sensitive to concerns of the community. In addition, the CHWs can and must become agents of change WITHIN the clinical setting. If they are truly CHWs they can help to humanize the system, and indeed in at least one example we know, they actually LEAD the patient care team. In all we do, we should be advocating for employers to "let CHWs be CHWs"

To end, it is quite inspiring to see Rhode Island move forward as a state that puts attention to the social determinates of health and recognizes the need to build leadership within the community to improve the health of the RI community at large. Thank you for this opportunity to review the State Health Care Innovation Plan and we hope you take our comments under advisement.

Sincerely,

Dannie Ritchie, MD, MPH
Clinical Assistant Professor Family Medicine
Lead, Transcultural Community Health Initiative
Brown University Center for Primary Care and Prevention
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dannie_ritchie@brown.edu

Dan Meuse <dmeuse@ltgov.state.ri.us>

Public Comments

Beth Lamarre <chwassociationri@gmail.com> Tue, Nov 26, 2013 at 4:06 PM
To: "shipcomments@ltgov.state.ri.us" <shipcomments@ltgov.state.ri.us>

November 25, 2013

I am writing in response to your call for public comments on the RI State Healthcare Innovation Plan. I am the Manager/Director of the Community Health Worker Association of Rhode Island (CHWARI), a trade association for the CHW workforce. CHWARI provides certification training, professional development, networking opportunities and other services for the state's CHWs.
CHWARI and CHW stakeholders are very pleased to see the inclusion of Community Health Workers in the State Healthcare Innovation Plan (SHIP), and hope to see an increase in the use of CHWs in efforts for healthcare outreach and impact on social determinants of health.
Community Health Workers have been an integral part of the healthcare workforce in RI and across the country for decades, and the positive impact they have had is becoming more and widely known.

In the SHIP, on page 34, it is mentioned that "Community Health Workers are under-recognized", and more specifically, that the "definition of Community Health Worker remains unclear". While it may not be well known throughout the healthcare and social service industries, there is a nationally accepted definition of Community Health Worker provided by the American Public Health Association's CHW section. A Community Health Worker is defined as "is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery." Moreover, there is an unclear understanding by the general public of the role and responsibilities of CHWs. However, there are nationally accepted standards, created by the CHW National Education Collaborative, that dictate the core competencies required of all Community Health Workers. In Rhode Island, these national core competencies are the foundation for CHWARI's CHW certification program.

When considering the final details of the SHIP, I would recommend that these nationally accepted definitions, core competencies and related curricula are considered and integrated. Using these references and CHWARI as a resource, all health care and social service professionals can be educated about the vital role of CHWs.

Please contact me with any questions or for more information on the CHW workforce.

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Beth Lamarre
Manager, Community Health Worker Association of Rhode Island (CHWARI)
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Opioid Treatment Association of Rhode Island (OTARI)

Addiction Recovery Institute • Center for Treatment and Recovery • CODAC
Discovery House • Providence Metro • The Journey

November 26, 2013

Office of the Lt. Governor
State House : Room 116
Providence, RI 02903
Attn: Public Comments

Dear Lt. Governor Roberts:

Thank you for the opportunity to provide comment on Rhode Island's State Healthcare Innovation Plan.

It has been widely known that mental health and substance use disorders are costly in all sectors of society. Rhode Island is no different. It is also known that timely, focused and effective treatment can, and does, result in decreased healthcare costs. Indicated and appropriate treatment and recovery efforts also create healthier families and communities, greater productivity, reduced criminal behavior and, over all, have been demonstrated to produce value in excess greater than their cost.

The members of OTARI include every Opioid Treatment Program (OTP) licensed and accredited by the Substance Abuse and Mental Health Services Administration (SAMHSA), Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), and the Commission on the Accreditation of Rehabilitation Facilities (CARF). The members are also licensed by Rhode Island's Department of Health and registered and authorized by the US Drug Enforcement Administration (DEA).

Currently, OTARI members serve over 3500 patients, diagnosed with opioid dependence, who receive methadone as part of an evidence-based comprehensive treatment and recovery plan. Not included, but in addition to those served by OTARI, is a cohort of patients receiving other forms of opioid treatment (Suboxone®) or Vivitrol® in private, or other practice settings.

The members of OTARI (collectively) have provided treatment, recovery, prevention and education services to Rhode Island's citizens since 1971 and, along with other providers has a great interest and stake in how these services will be provided in the future. Additionally, we have a great interest and stake in assuring that care is delivered in a manner that maintains and improves upon identified best practice and is provided by individuals and entities possessing the skills to do so.

Rhode Island has had a long and successful history of supporting and partnering with community-based providers to serve the evolving needs and unique characteristics of these populations.

While the Full Committee, as listed, represents a broad constituency, we are puzzled by the lack of any representation or participation from members of the community provider groups that most serve the addiction and substance use disorder populations. Likewise, there appears to be no representation from the Drug and Alcohol Treatment Association of Rhode Island (DATA-RI) which represents this field much like The Rhode Island Council of Community Mental Health Organizations (RICCMHO) represents the mental health centers.

c/o CODAC – 1052 Park Ave., Cranston, RI 02910 • 401-275-5039 • 401-942-3590 (F) • mrizzi@codacinc.org

With respect to the Committee - Is it possible that our "group" was not invited to participate? Is it possible that our "group" failed to respond to an earlier invitation? In either case, we believe the plan would be significantly enhanced and improved with the input of the provider group serving this particularly unique and challenging population. Rhode Island's opioid treatment programs should be included as contributing providers in the behavioral health care network, offering services they are uniquely trained to do.

I am pleased to note your "invitation" on Page 61, *"The State would welcome additional suggestions for strategies to address Rhode Island's significant behavioral health and substance abuse problems"*. I know that I, and I'm sure my colleagues both at OTARI and DATA-RI and other members of the addiction and substance use disorder network, would welcome the opportunity to provide insight, education, and suggestions designed to improve the plan.

I look forward to hearing from you regarding this opportunity.

Best wishes for the Holidays.

Sincerely,

Michael Rizzi, Chair
OTARI

c/o CODAC – 1052 Park Ave., Cranston, RI 02910 • 401-275-5039 • 401-942-3590 (F) • mrizzi@codacinc.org

November 26, 2013

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It has been widely known that mental health and substance use disorders are costly in all sectors of society. Rhode Island is no different. It is also known that timely, focused and effective treatment can, and does, result in decreased healthcare costs. Indicated and appropriate treatment and recovery efforts also create healthier families and communities, greater productivity, reduced criminal behavior and, over all, have been demonstrated to produce value in excess greater than their cost.

CODAC Behavioral Healthcare has provided treatment, recovery, prevention and education services to Rhode Island's citizens since 1971 and, along with other providers has a great interest and stake in how these services will be provided in the future. Additionally, we have a great interest and stake in assuring that care is delivered in a manner that maintains and improves upon identified best practice and is provided by individuals and entities possessing the skills to do so.

Currently, there are thousands of Rhode Islanders in treatment for addiction and other substance use disorders. In fact, there are over 3500 patients receiving Medication Assisted Treatment (MAT) for opioid dependence provided by Rhode Island's six (6) MAT, or methadone providers. This does not include those receiving other forms of opioid treatment (Suboxone®) or Vivitrol® in private, or other practice settings. Nor does it include those receiving treatment and recovery support for other drugs of abuse.

Rhode Island has had a long and successful history of supporting and partnering with community-based providers to serve the evolving needs and unique characteristics of these populations.

While the Full Committee, as listed, represents a broad constituency, I am puzzled by the lack of any representation or participation from members of the community provider groups that most serve the addiction and substance use disorder populations. Likewise, there appears to be no representation from the Drug and Alcohol Treatment Association of Rhode Island (DATA-RI) which represents this field much like The Rhode Island Council of Community Mental Health Organizations (RICCMHO) represents the mental health centers.

With respect to the Committee - Is it possible that our "group" was not invited to participate? Is it possible that our "group" failed to respond to an earlier invitation? In either case, we believe the plan would be significantly enhanced and improved with the input of the provider group serving this particularly unique and challenging population. Substance abuse treatment programs should be included as contributing providers in the behavioral health care network, offering services they are uniquely trained to do.

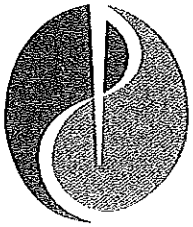
I am pleased to note your "invitation" on Page 61, *"The State would welcome additional suggestions for strategies to address Rhode Island's significant behavioral health and substance abuse problems".* I know that I, and I'm sure my colleagues both at DATA-RI and other members of the addiction and substance use disorder network, would welcome the opportunity to provide insight, education, and suggestions designed to improve the plan.

I look forward to hearing from you regarding this opportunity.

Best wishes for the Holidays.

Sincerely,

Michael Rizzi
President/CEO



The
Providence
Center

November 26, 2013

Mental health
and substance
use care and
treatment services
for adults, children,
adolescents
and families

The Honorable Elizabeth Roberts
Lieutenant Governor
State House
Room 116
Providence, RI 02903

Attn.: Public Comments

Dear Lieutenant Governor Roberts:

Thank you for the opportunity to offer comments and suggestions concerning the most recent draft of the State Healthcare Innovation Plan. Before I outline the suggestions my colleagues at The Providence Center and I have to offer, I'd like you to know how much we appreciate the transparency and inclusiveness that have characterized the process of developing this plan. It takes a lot of time and energy to ensure that as many citizens as possible have their say on the important issues this plan covers. You and your staff are to be commended for your commitment to hear every voice.

I'd also like to underline a theme that runs throughout the draft plan. As the CEO of the state's largest community mental health organization, I would like to reinforce an important concept that runs through many of the plan's recommendations – that is, that Rhode Island needs a more efficient, integrated health care system that includes a wide variety of behavioral health services if we are to make any progress in meeting the unmet health needs of our citizens and to begin to build a more efficient healthcare system. You will notice that I did not say that we need to invest more resources in the behavioral health system. For too long, that system has operated separately from the rest of the healthcare world. We believe strongly that new approaches that integrate behavioral health with the rest of the healthcare system will help our state address some of its highest cost, lowest value healthcare problems.

This integration is no simple matter. It is far more than simply co-locating behavioral health and primary care services. Making what have been conceptualized as two separate systems work together will take detailed planning and support from state agencies and the Care Transformation and Innovation Center contemplated in the draft plan. In The Providence Center's experience, models for integration are very different depending on the level of acuity of an individual's behavioral health concerns. We would look forward to working with a wide variety of constituencies to build on our successful experience with integrated services.

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Further, we applaud the draft plan's "one size doesn't fit all" approach. We do believe that models and approaches must be different depending on the severity of an individual's condition. We would note however that people move in and out of these risk categories. This is especially true of many behavioral health conditions as they are often recurrent, chronic illnesses. In developing integrated, enriched services, we must develop ways to ensure that supports can follow the person as his or her risk category changes.

We would also like to very strongly support the plan's inclusion of recovery support services as a way to address the needs of those affected by substance abuse disorders. Our work over the last several years with recovery supports and recovery coaching, largely conducted through our Anchor Recovery Community Centers program, is some of The Providence Center's most transformative work. Recovery supports are built around the assumption that the vast majority of those affected by addictions can and will recover. Rhode Island would benefit greatly from a better developed, better supported system of recovery supports.

We would like to express our support for the inclusion of behavioral health specialist staff and recovery coaches on community health teams as described in the draft plan. We especially would like to express our support for the recognition of the unique expertise of recovery coaches, either as part of these teams or as part of a larger system of recovery support services. We believe that provision of recovery supports can dramatically reduce the need for repeat substance abuse treatment. The overlapping effects of substance abuse and mental illnesses are a major factor in our state's pattern of high-cost care.

Regarding the plan's recommendations concerning CurrentCare, we believe this system is critical to ensuring a free flow of information bearing on patients' care. In addition to the recommendations in the draft plan, we would also like to urge development of a means for electronic health record systems to automatically check a patient's enrollment in CurrentCare. In our work to encourage our clients' participation, perhaps because of the continuing stigma surrounding receiving behavioral health services, our clients are reluctant to enroll, where they seem to enroll more freely in their primary care setting. Strengthening CurrentCare's ability to work across the whole system and addressing gaps that prevent healthcare providers from accessing full prescription records for clients no matter where they fill or pay for prescriptions would be significant improvements.

As the state plan looks toward facilitating the development of programs such as the Community-based Care Transitions program and the Advanced Payment Accountable Care Organization Program, we would urge an expansion of these programs focus beyond single disease states. For example, a patient with COPD's post-hospital discharge experience and outcomes will be significantly improved if a program screens and treats that patient's underlying depression. When these programs focus on outcomes limited to a single disease or condition, often these underlying issues are not addressed.

We would like to recommend that the draft state plan develop ways to connect with the state's roll-out of its duals initiative, particularly the second phase of the rollout which is scheduled in 2014 to incorporate dual eligibles with serious mental illness. The duals program can be an important source of support for the new programming this plan envisions, but only if the new kinds of services to be developed are made a covered service.

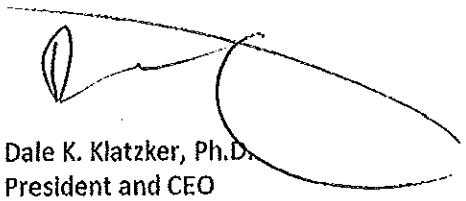
We appreciate the plan's emphasis on deeper engagement of patients. Because stigma and low expectations for improvement are so much attached to patients affected by mental illnesses and substance abuse disorders, we urge that these strategies promote recovery as a goal. We have adopted as an organizational expectation that the vast majority of individuals will recover when provided with the right services and support at the right time. We would urge that the plan develop this same idea as a way to deepen the engagement of individuals with mental illness and substance use disorders.

Regarding the plan's proposal to facilitate the development of primary care-led ACOs, we would like to point out that for many of those whose primary diagnosis is either a serious and persistent mental illness or a substance use disorder, they may be better served in a behavioral healthcare-led specialty ACO. The development of this kind of new model would need to be supported by resources provided by dedicated financing. There are a limited number of groups that have the capacity to take on the financial risk inherent in an ACO model. The proposed Care Transformation and Innovation Center could potentially develop ways to "backstop" performance risk at least for a transitional period.

We also strongly support the development of the sobering center mentioned in the draft plan. The Providence Center is one of several groups interested in collaborating on a Providence-focused pilot. Efforts should be made to evaluate and learn from this pilot to inform the development of other efforts.

Once again, thank you for the work you and your staff have done to promote such a thorough exploration of how we can work together to improve the health of all Rhode Islanders.

Sincerely,



Dale K. Klatzker, Ph.D.
President and CEO

Neighborhood Health Plan of Rhode Island

RE: Comments on Final Draft of Rhode Island State Health Care Innovation Plan

On behalf of Neighborhood Health Plan of Rhode Island we respectfully submit comments on Rhode Island's State Health Care Innovation Plan. We applaud the Lt. Governor and the State Innovation Model (SIM) Workgroups for their efforts behind this ambitious and wide-ranging plan. We offer the following comments for your consideration:

Innovations Grid (starting on Page 3)
Overall, the grid and the document would be strengthened with the addition of data to validate the many assumptions in the document.

- Include data to substantiate the health care challenges listed on the grid.
- Provide the references associated with the best practices listed under Innovation/Activity/ Intervention.
- Target performance – when possible include quantifiable objectives as a part of the outcomes measurement.

Prioritization
The document is broad and includes many laudable goals and ideas. However, the focus on accomplishing these goals could be improved by prioritizing a smaller number of initiatives and adding a calendar for sequencing when these efforts will be accomplished. To help with the prioritization we suggest:

1. Payment and Delivery Innovations and Tools
   - Focus on affordability by using the Affordability Standards set by the Office of the Health Insurance Commissioner's (OHIC). Similar standards are now required by Medicaid managed care as well. The progress made by the OHIC is important to build upon and to implement fully and successfully, which will likely encompass many of the initiatives listed in the Payment and Delivery section.
   - Develop state-based standards for EMR adoption with the goal of moving over time to a single, interoperable EMR platform across all providers. Rhode Island can capitalize on its geographic advantage and defined provider community to establish a single EMR that will yield true integration and remove fragmentation across health care delivery settings.
   - Create an Advisory Board for the Rhode Island Care Transformation and Innovation Center comprised of providers, all payers, consumers, businesses and academic institutions – Neighborhood would be pleased to fully participate on the Board.
   - Expand Community Health Teams (CHT) – we strongly encourage creating a CHT model that is flexible and allows for full alignment with primary care. As written in the draft SHIP, the CHTs sit outside of primary care and have the potential to create fragmentation when integration needs to be promoted. We would like to see CHTs embedded in PCMHs instead of establishing independent organizations as implied in the plan.

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- Provider Directory – a unified provider directory is a significant undertaking and administratively burdensome task requiring ongoing maintenance. We recommend removing this from the list or making it a low priority.

2. Workforce Development
   - We recommend consideration of more specific goals in the area of promoting a strong primary care workforce. There should be more active involvement and alignment of the schools of higher learning in the state. CCRI, URI and Brown should provide ample opportunities to create the primary care workforce of the future. There have been discussions about URI developing a medical school. If the state plans to further explore forming a medical school based in URI, one guiding principle linked to funding is to make URI our state's main primary care training center.
   - We support the development of more primary care residency programs in PCMH sites. However, residency slots may be closely controlled by a national body and no institution is allowed to add positions. If this is the case, SIM can be an impetus in addressing this particular constraint.
   - We recommend that training of teamwork skills required to support and maintain PCMHs be included in the teaching curriculum for all providers (physicians, nurses, PAs, NPs, and BH providers).
   - We suggest shifting the focus of behavioral innovations from co-location to true integration of primary and behavioral health care. PCMHs should be managing routine behavioral health issues such as depression and anxiety using an integrated care team comprised of primary care, behavioral health and care coordinators.

3. Behavioral Health
   - We believe that one of the most urgently needed "innovation priorities" is forming a statewide coordinated multi-provider/stakeholder initiative to prevent and treat addictions to medications such as opiates/benzodiazepines. There are indications that substance use disorder is a significant source of morbidity and mortality in the state. These addictions add to the disease burden in the state and are a key cause of resource drain on many parts of the health care, mental health, social services, and correctional systems. Addictions can drive ED visits, hospitalizations, and inappropriate use of a range of health care resources.

4. Patient Engagement
   - Consider developing a goal specific to stimulate health care consumer engagement. RI has the potential to dramatically change the way health care is delivered and the manner consumers receive care as well as managing their own health. Specifically, the plan should call for the creation of a consumer assistance group charged with the implementation across the health care delivery system of best practices to further health literacy, informed decision-making and patient empowerment. RI has the opportunity to help transform health care consumers into savvy and informed purchasers of services, a critical step to ensuring overall innovation.

5. Population Health/Health Disparity/Social Determinants of Health Innovations

   - We strongly encourage a requirement to collect race and ethnicity data in all sectors of RI's health care system: state employees, Medicaid, HSRI, employers/commercial insurance. Currently, the availability and quality of this information is poor, making it difficult to create actionable interventions to improve the quality of care and service for racial and ethnic minorities.

We appreciate the opportunity to review and comment on the draft Innovation Plan and look forward to being a part of the ongoing collaboration to improve our health care system.

Sincerely,

Beth Ann Marootian, MPH
Director, Business Development

Peter M. Oppenheimer, Ph.D.
Clinical Psychologist
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November 26, 2013

Daniel Meuse
Deputy Chief of Staff
Office of Lieutenant Governor
State House Room 116
Providence, RI 02903

ATTN: Public Comments
shipcomments@ltgov.state.ri.us

Comments on the State Innovation Health Plan Proposal
from the
Rhode Island Psychological Association
and the
Coalition of Mental Health Professionals of Rhode Island

Dear Mr. Meuse:

I am writing to provide comments on the State Health Care Innovation Plan Proposal on behalf of the Rhode Island Psychological Association and the Coalition of Mental Health Professionals of Rhode Island.

I would like to thank Lieutenant Governor Roberts, your staff and you for the extensive and diligent work you have put into developing this proposal. We also appreciate the time and effort that everyone who is participating in this process is giving. Transforming Rhode Island's health care services to address the "triple aim" of accessible quality care at lower costs is truly daunting. We hope everyone respects how important this process is for the future of Rhode Island and all Rhode Islanders.

It is essential that we recognize that this proposal does not address all the details and nuances that need to be articulated to successfully implement the concepts proposed in the plan. We hope that everyone reading this recognizes and accepts that everything in this plan requires refinement and assessment before it can be functionally implemented.

There are a number of major issues we would like to address:

1. We have a number of concerns regarding how the behavioral health, mental health and substance abuse needs of consumers can best be met.

At any time 25-28% of people have a diagnosable mental illness (including substance abuse).[i] Yet, most people with mental illness and substance abuse problems don't get help.[ii] Most of the people who get help get it from their primary care doctors, but that is not always the best way to serve them, in part because primary care doctors do not have specialized mental health training. We are looking for ways to bring the science of behavior change to healthcare to help people develop and maintain healthier lifestyles and to help those with physical illness, mental illness and substance abuse problems address their problems more effectively. We also recognize that the cost of health problems to employers is estimated to be three times as great for lost productivity, absenteeism and turnover than the cost of treatment itself.[iii]

There is ample research showing that providing appropriate mental health care can reduce patients' medical costs and that integrating behavioral health care with medical care also reduces costs, while improving quality. Chiles, Lambert and Hatch (2006)[iv] reported an average of 20% savings from implementing psychological interventions. Crane et al (2008)[v] reported reductions in services from 38% to 78% for "high utilizers." The American Hospital Association (2012)[vi], Melek (2012)[vii], Loeppke (2007)[viii] and Knapp (2013)[ix], provide summaries and reviews of the cost savings potential of coordinating mental health services and primary care.

We recognize that studies are showing that the prevalence of mental illness in Rhode Island his higher than in other states.[x] The incidence of suicide attempts is higher than the national average while the rate of successful suicides is lower than in other states[xi]. It also appears that more Rhode Islanders get treatment than do people in other parts of the county. Yet there are also estimates that more people are hospitalized for mental health reasons than is necessary and that some people are getting their mental health care thorough emergency departments because they lack access to other entry points of entry for care. Thus while it is good that more people are able to access care in Rhode Island than elsewhere, not everyone is getting access to the care they need nor are they necessarily getting the most appropriate care.

Throughout the literature on integrated and collaborative care, patient behavior and their mental health and substance abuse issues are recognized to be significant factors in their ability to access and participate in care. There is a "Rising Risk" population that has one or two chronic conditions. It is important to recognize that many patients with mental health issues also have physical co-morbidities. Expanding the opportunities for patients in this category to receive health and behavior services could be the difference between whether they remain at this level or rise to the high risk category (and thus

become even more expensive to treat). Psychologists are the leaders in health and behavior assessment and intervention services.

While the plan recognizes the importance of behavioral health interventions and that there is a role for behavioral health clinicians in PCMHs, it is not clear what that role should be and how such a role will be filled. The co-locations strategies described on page 61 under the heading "Behavioral Health Innovations" are incomplete. They do not account for the wide range of needs of patients for behavioral health, mental health and substance abuse services. It is essential that the plan further clarify how these needs will be addressed with the PCMH structure. It is important to consider what services can be provided by the PCMH itself and what services will be need to be accessible elsewhere. PCMH's will encounter behavioral health needs from common low-level issues to severe mental illness and low frequency issues. It is important to recognize that no physician or behavioral health clinician in a PCMH will be capable of addressing all the needs that will present in the office. We are willing and eager to work with the State on the appropriate inclusion of behavioral health care in PCMHs.

There are several issues and barriers that we identify that need to be addressed to provide proper behavioral health, mental health and substance abuse services to consumers, and to enable behavioral health clinicians to make the transition to healthcare reform.

A. Stigma around and discrimination against people with behavioral health issues, mental illness and substance continues. We must work to reduce this stigma and promote the ability of people who suffer from these issues to obtain the help they need for them. We must work to ensure that the Mental Health Parity and Addiction Equity Act of 2008 is faithfully implemented throughout the state.

B. Behavioral health clinicians are not included in information technology funding. That is now creating a barrier in our ability to work with physicians and hospitals, and that undermines efforts to communicate and coordinate care. Behavioral health clinicians will experience barriers to participating in EMR, Current Care and other communication mechanisms. Senator Rob Portman has just introduced the Behavioral Health IT Coordination Act of 2013, S. 1685, it would cover clinical psychologists in public and private psychiatric hospitals, community mental health centers, and residential or outpatient mental health or substance abuse treatment facilities. It would be helpful for Healthy Rhode Island to support this bill. If a federal solution is not promptly forthcoming the Rhode Island Care Transformation and Innovation Center (RICTIC) could provide funding and technical support to Rhode Island's psychologists and other professionals who are excluded from HITECH.

C. The current CPT codes are not transforming with the goals of healthcare reform. The codes do not account for the communications and quality assessment activities in which behavioral clinicians will need to engage to participate in coordinating and assessing the efficacy of their care. For instance there are no codes that account for the time clinicians spend communicating with other healthcare professionals either in direct communications or via the exchange of secure communications (nor for the infrastructure costs of this as well). We are also not included in codes that provide for transitional care management services. However, these services are currently captured by CPT codes that are considered evaluation and management services; as such most third party payers will not reimburse psychologists for these services. It would be helpful for the SHIP to encourage and support the development of strategies to reimburse professionals for services that are needed to make healthcare reform work but that are not included in the current procedure codes. The work that psychologists do in providing care coordination and transitional care management services for their patients must be recognized and reimbursed appropriately.

D. Psychologists are excluded from the Medicare definition of Physician. Including psychologists in the definition would allow psychologists to be treated like all other non-physician providers already included in the Medicare physician definition, thereby ending unnecessary physician supervision without increasing Medicare costs. There is a bill on Congress to that effect now. (H.R. 794 sponsored by Sen. Sherrod Brown and Rep. Jan Schakowsky). It would be helpful for HeathlyRI to support this legislation.

E. The ownership and decision making structures of PCMHs and ACO-like organizations are unclear. It is important that rules ensure that the needs of patients are addressed and respected. It is also important rules protect the professional integrity and independence of all professions providing service in the system. The "Medical Neighborhood" concept must be designed and utilized in a way that allows behavioral healthcare professionals to practice independently and collaborate with other healthcare professionals.

F. There are barriers to health service providers coordinating and collaborating in business arrangements that may interfere with the achievement of the triple aim. We have already alleviated one such barrier: we have revised the Professional Service Corporations statue (RIGL7-5.1-2 and 7-5.1) to allow professional service entities to be owned by wider range of healthcare professions. However, the federal antitrust laws may continue to serve as a barrier to some efforts to collaborate and cooperate without the forming large corporate entities that might create to a more competitive business environment in healthcare. These barriers should be monitored and addressed if it is the interest of the people of Rhode Island to do so.

G. It is essential that in planning the transition to coordinated care that we consider what services and policies will lead to the desired outcomes of a healthier and more productive community who has access to quality care and appropriate costs. That will require redistribution of resources. While some services will be appropriately curtailed or reduced, some should be enhanced and expanded. It is clear to us that to achieve the population health goals of healthcare reform that behavioral health, mental health and substance abuse services should actually be expanded and enhanced, and that this investment will lead to reductions in medical costs, and a healthier and more productive populace. For a generation Rhode Island has lacked/has had a great shortage of intermediate level services for mental health, behavioral health and substance abuse. Healthcare reform provides an opportunity to assess the entire system and to redirect resources where they will be most beneficial.

2. In the effort to use "accountable payment models based on the concepts of Accountable Care Organizations ("ACO") (pg. 38) we are concerned that caution be used to ensure that there remain opportunities for a diverse and competitive marketplace for healthcare services. We are very concerned that this approach could lead to the conglomeration of healthcare services under the banners of very few service providing entities. If that happens diversity and innovation could suffer, and the oligopoly that results would undermine future efforts to provide accessible quality services at appropriate costs. We are concerned that we are at risk for problems similar to what we have experienced with the limited number of health insurance companies over the past 20 years where we do not have enough competition from the vendors to enable the competitive environment.

We would like the proposal to enable and encourage less centralized entities to participate in providing coordinated healthcare services in a collaborative fashion without having to form unified corporate structures, and to ensure that new services providers have a way to enter the market. The state can help smaller entities to address barriers to such collaborations.

3. The plan relies heavily on the assumption that the current funding mechanism of fee-for-service-payments does not encourage efficiency in spending, and that such efficiency can be addressed by transferring risk to health service providers. It is important that we fully consider the implications of transferring control of financial resources and risk to service providers. It is important that plans be structured in ways that incentivize behaviors that are desired, and that do not crate unintended consequences or inappropriate secondary gains. We must recognize that if this plan is implemented along the proposed structure that while nearly all healthcare service providers and funding sources are well-meaning and honest, not all are and that some will take advantage of whatever there is to be taken advantage of just as they have done

in the fee-for-service system. Control of financial resources and the assumption of risk created these dynamics in the insurance, banking and investment industries, and it is at risk to occur in healthcare.

4. The plan focuses entirely on one financial strategy: "Rhode Island is committed to supporting the transition from the current fee for service health care environment to a system in which providers are accountable for the health of the attributed patient population. The state will encourage payment models supported by CMS including pay for performance, bundled payments, and shared savings programs as steps to reach full shared financial responsibility" (pg 38). The plan accepts the assumptions that there will be a multi-payer system and CMS assumption that it is desirable to pass risk to providers. The private insurance companies usurp significant amounts of the money spent by purchasers (government and private) for administration and profit. The Affordable Care Act has set a basic limit on how much they can take for their own purposes. The plan does not address how funding sources could achieve greater efficiencies and reduce their costs. The plan does not address the way medical equipment and pharmaceuticals are purchased. Equipment and pharmaceuticals are much more expensive in the United States than they are elsewhere, and there is no mechanism for determining appropriate prices for them as there is for medical services. The plan also not address where funds are expended in wasteful or other ineffective ways.

5. It is important to recognize that the small business and self-purchase insurance policies being offered by HealthSourceRI are largely high deductible high co-pay policies. Mental health professionals know that these plans create significant barriers to engaging and participating in assessment and treatment for many people covered by these plans. Some consumers will decline to come for services recognizing they cannot pay the amounts for the deductible and co-pay. Some consumers have accurately calculated that they could participate in weekly mental health treatment through their policy year and never meet their deductible. As such they effectively have no mental health benefit at all. Likewise, high copays also lead people to avoid participating in treatment.

Health plan benefit rules can create even more barriers. Sometimes plans do not allow patients to be seen for multiple services by different providers on the same day (i.e. they could not see their psychiatrist for their psychopharmacology and their psychotherapist on the same day.) Some plans require their insured to pay multiple copays even when the patient is seen by their primary care physician and the on-site behavioral health clinician in the PCMH the same day. We ask that the plan address and remedy these issues.

6. We have concerns that the goals of achieving population health objectives while preserving patient choice may not be entirely compatible. The best opportunity to achieve this would to appear to be if the system is comprehensively inclusive of all consumers, service providers and funding sources as occurs in many countries with national health plans. We recognize that most consumers indicate that they want to preserve their ability to choose their healthcare providers. It is reasonable to view this as part of a consumer's responsibility for their own healthcare. Most people would have difficulty comprehending how if they are told on one hand that they are responsible for their healthcare choices that they must follow the dictates of a plan or healthcare professional regarding where they get services, and the services they receive.

However at this time the insurance companies are in the process of developing and implementing more restrictive networks than Rhode Islanders have experienced in recent years. The merits of this tactic versus the merits of consumer choice are not being openly addressed in a manner that will help consumers to realistically understand the implications of the issue so that they can make informed decisions. Healthy Rhode Island needs to address this issue with the public at large.

7. It is important that state law and regulations be monitored and updated as necessary to address the changes in insurance and service delivery that are occurring. Beyond revising exiting laws and regulations, the implementation of Community Health Teams and case management will require that there be consideration of credentialing requirements (possibly a license) and legislation and regulation to define the Team members' scope of practice.

8. We are concerned that the actuarial data that has been presented in the recent meetings about the plan does not include sufficient information for the community to accurately assess and interpret that data. The full data, and Milliman's methodology needs to be shared promptly. The information presented is different from what we would have expected: that the rate of spending on mental health and substance abuse has been declining in proportion to overall health care spending[xii] and that it has stayed the same as fraction of Gross Domestic Product while overall health care costs have risen steeply[xiii].Government and private mental health and substance abuse reimbursement rates have not kept pace with the overall healthcare spending and the cost of living. In many cases they have declined while the costs of providing services continue to rise. Current reimbursement rates put the future of quality behavioral healthcare services in peril.

What is blatantly clear to us is that in light of all of the data showing how important behavior, mental health and substance abuse are towards the overall health of the population, and the healthcare costs that these issues create that not nearly enough resources are being allocated to address the behavioral, health, mental health ans

substance abuse needs of the community. A truly innovative healthcare system will allocate the resources necessary to address these issues and ensure that mental health and substance abuse are truly addressed with parity.

9. It is important that in the process of healthcare reform that information be provided to consumers that help them to understand and make informed judgments about their insurance coverage, lifestyle choices and medical care. This should include information that helps consumers understand the covered benefits, limitations and exclusions of their plans and how those factors impact upon their premiums, deductibles and copays.

10. The process of healthcare reform is truly complex. It is important that Healthy Rhode Island reach out to all stakeholder constituencies and make the process as inclusive and transparent as possible. We appreciate that the plan emphasizes the need to include all provider types, including behavioral health.

Thank you for considering our concerns. In our comments we have addressed a number of issues that will require ongoing exploration and discussion. We are eager to participate in this effort in the service of achieving the triple aim. The Rhode Island Psychological Association and the Coalition of Mental Health Professionals of Rhode Island look forward to continuing to work with you in this effort.

Sincerely,

Peter M Oppenheimer Ph.D

Peter M. Oppenheimer, Ph.D.
Clinical Psychologist

President-Elect
Rhode Island Psychological Association

Chair
Coalition of Mental Health
Professionals of Rhode Island

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Rhode Island Quality Institute

November 26, 2013

The Hon. Elizabeth Roberts
Lt. Governor, State of Rhode Island
State House Room 116
Providence, RI 02903
ATTN: Public Comments

Re: Draft State Healthcare Innovation Plan

Dear Lt. Governor Roberts:

On behalf of Rhode Island Quality Institute, I am pleased to submit comments on the draft State Healthcare Innovation Plan that was released for public comment on November 6, 2013. We applaud the efforts of your office to develop this roadmap for the state and believe that its creation represents an important step toward a transformed healthcare system that is coordinated, value-based, and sustainable. In particular, we strongly support the State's pursuit of the goal to transition at least 80% of covered lives into value-based care arrangements within 5 years and believe that this goal is the key driver for health system transformation. We recommend that the State prioritize this goal and the strategies needed to achieve this goal above all other items included in the plan. We also recommend that the State provide a clearer roadmap for how it intends to achieve the 80% goal. To make the State Healthcare Innovation Plan more actionable and to establish a path to success, we encourage the State to more explicitly connect the 80% goal to the strategies included in the plan, more specifically define the relevant strategies, and more clearly explain how the State will implement the strategies. In particular, we respectfully suggest the following changes to the SHIP:

1. Establish clearly defined goals and objectives for the Stakeholder Coalition that will develop accountable care strategies and structure, and provide regulatory or other authority to empower the convener to hold the coalition accountable to the goals and objectives. The work of the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) over the past five years demonstrates that a coalition-led initiative can achieve important and impressive outcomes, but in the absence of clearly defined goals and objectives, it may take substantial time for the coalition to achieve those outcomes and spread accountable care to a large proportion of the state's population. To achieve its goal to transition at least 80% of covered lives into value-based care arrangements, the State must take a more deliberate approach than would be observed under an organic process.

2. Adopt stronger language related to the use of value-based purchasing options by the State as a payer, and establish clearly defined goals for the proportion of State and municipal employees and Medicaid beneficiaries who will be in value-based arrangements. The State needs to demonstrate leadership in driving adoption of value-based purchasing and should take full advantage of its vast purchasing power toward achievement of the goal to have 80% of covered lives in value-based care arrangements.

3. Establish clearly defined goals and objectives for expansion of PCMH and ACO models to additional providers, invest in the infrastructure needed for continued expansion of the models, encourage local testing and refinement of the models, and promote the establishment of new PCMH and ACO initiatives. As demonstrated by CSI-RI, PCMH and ACO initiatives require substantial project management and infrastructure, particularly when they are executed on a large scale. The State should ensure that appropriate resources are available to effectively support these initiatives. It should also be recognized that, while many of us believe that the PCMH and ACO models improve care, there is limited evidence to support either model. Further testing and modification of the PCMH and ACO models may be necessary to achieve the Triple Aim, particularly for populations with special care needs, such as people with serious and persistent mental illness, home-bound elders, and people with developmental disabilities. In addition, the State should make a strong investment through the Rhode Island Transformation and Innovation Center or other entity to build and successfully execute a large-scale quality improvement infrastructure that can effectively help PCMH and ACO initiatives achieve their goals, potentially using Rhode Island's successful ICU Collaborative as a prototype.

4. Prioritize the creation of a centralized data aggregation entity, and align the aggregation entity with the Rhode Island Care Transformation and Innovation Center. Easy access to timely and reliable data and the ability to act on that data are both critical to the transformation to a value-based health system. At present, providers, payers, and other stakeholders have insufficient access to data to meet their needs, and they often struggle to use the data that is available to improve care. Addressing both of these challenges will be necessary for Rhode Island to successfully transform to new payment models.

5. Invest in incentive-based programs and use regulatory power (where appropriate) to achieve widespread adoption of health information technology (HIT). We believe that increased adoption of HIT is critical to the success of Rhode Island's efforts to promote value-based purchasing arrangements. Over the past 10 years, Rhode Island Quality Institute has worked with a broad base of partners to support adoption of HIT and encourage use of CurrentCare, but we believe a stronger approach that leverages both incentives and regulatory power will result in more rapid adoption of HIT and better position the state for successful transition to a value-based system.

Thank you for the opportunity to participate in the planning process and to review the draft plan. We appreciate your consideration of our comments. Please do not hesitate to contact me at ladams@riqi.org if you have any questions.

Sincerely yours,

Laura Adams
President & CEO

Dan Meuse <dmeuse@ltgov.state.ri.us>

Fwd: State Health Innovation Plan

Jason Rafferty <Jason_Rafferty@mail.harvard.edu> Tue, Nov 26, 2013 at 2:02 PM
To: shipcomments@ltgov.state.ri.us

Re: State Health Innovation Plan"

As a pediatrician and child psychiatrist, I am concerned that the draft State Health Innovation Plan's gives very limited attention to children, families, prevention, and public health. The most cost effective measures to reducing morbidity and promoting well being state-wide is to focus on children and social determinants of health. Disease, illness and injury always occurs within the context of one's family, neighborhood, and state politics. Social determinants including poverty, unequal access to preventative care, lack of education, stigma and racism play an important influential role in the equity and health of our citizens. Almost 35 % of urban high school students in RI drop out before graduation, which does not fare well for the future health of our state. Second, healthy development is also adversely influenced by young children's exposure to extremely stressful conditions, such as recurrent abuse, chronic neglect, caregiver mental illness or substance abuse, and/or violence or repeated conflict. Toxic stress, or prolonged activation of our internal stress response systems, can disrupt brain development increasing the risk for stress-related disease and cognitive impairment well into the adult years. However, research shows that, even under stressful conditions, supportive, responsive relationships with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress response. Therefore, our state health plan needs to incorporate a stronger focus on expanding pediatric medical homes to all children, providing accessible and high quality mental health services to both children and their parents, and supporting our social systems (schools, early childhood education centers, neighborhoods and communities) to ultimately promote developmental and behavioral health.

Jason Rafferty, MD/MPH

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DATA
Drug and Alcohol Treatment
Association of Rhode Island
Representing Treatment and Prevention Providers

November 26, 2013

To whom it may concern,

The Drug and Alcohol Treatment Association of Rhode Island represents over 25 agencies which provide Substance Abuse and Behavioral Health treatment services in the state of Rhode Island.

In the process of a review of the draft of Rhode Island's State Healthcare Innovation Plan it has come to our attention that there was no mention made of the comprehensive SA treatment network that exists in this state.

On any given day 4,000-5,000 individuals are receiving SA treatment services. The majority of which is not provided at a mental health center.

The introduction mentions that the plan does provide a review of the current health care system. We feel that addiction treatment is in fact a significant part of the health care system and to omit this critical component renders this plan incomplete and inaccurate. Most of our member agencies are providing proven evidenced based treatment services with excellent patient outcomes.

In addition our concerns are the following:

- Although behavioral health is referenced throughout the document, it is unclear as to its definition. More often than not, community mental health centers are referenced and discussed; yet the substance abuse treatment network is not detailed or even mentioned. If behavioral health is included, it is not clearly articulated within the plan which leads the reader to make unsubstantiated assumptions.

-Substance abuse refers to a set of related conditions associated with the consumption of mind – and-behavior-altering substances that have negative behavioral and health outcomes. In addition to significant negative primary health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in addressing public health issues.

-As it is true with any mental-health diagnosis, there is no one test that definitively indicates that someone has chemical abuse or addiction. Therefore a comprehensive medical, family and mental health assessment must be completed by practitioners and individuals specifically educated and credentialed in the field of addictions. The community health teams as defined in the document make no mention of licensed or credentialed workers in the field of addictions. Also, while recovery coaches are mentioned, they are only one member of the multidisciplinary team required to support and meet the needs of the patient.

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- The document references an analysis conducted by Milliman revealing diagnosis information across all payers (Commercial, Medicaid and Medicare). This analysis does not include addictive disorders. To this end, it is important to also recognize that Rhode Island ranks 13th with the highest overdose mortality rate in the United States;

- In recent years, the impact of substance and alcohol abuse has been notable across several areas including adolescent abuse of prescription medications and Substance Abuse issues with military members, veterans and their families. In addition, as the federal government implements health care reform legislation, attention will focus on the provision of services for substance abuse and mental health illness, including new opportunities as a result of the new Parity regulations. Access to and coverage of addiction treatment and prevention services will undoubtedly increase.

- Rhode Island has nationally recognized experts in the field of Chemical Dependency and Addiction located at Brown University's Center for Alcohol and Addiction Studies, the University of Rhode Island and R.I College Department of Psychology. We also have Individuals involved with the following professional associations: American Academy of Addiction Psychiatry, American Society of Addiction Medicine and the International Nurses Society on Addictions. To our knowledge, no individuals from these organizations or groups were involved in the actual development of this document.

In Summary, we are requesting representation from the substance abuse provider community and the opportunity to provide input as referenced on page 61 of the plan. We are confident that with the inclusion of specific addiction disorder information, data and services the plan will more accurately reflect the current status of the behavioral healthcare field. It will also provide a healthier and more promising roadmap for the future for all Rhode Islanders.

Sincerely,

David Spencer, MBA, MPA
Executive Director
Drug and Alcohol Treatment Association of Rhode Island

235 Promenade Street | Suite 455
Telephone: 401-274-1771

RIHCA
RHODE ISLAND HEALTH CENTER ASSOCIATION

Providence, Rhode Island 02908
Facsimile: 401-274-1789

November 26, 2013

Office of Lt. Governor
State House Room 116
Providence, RI 02903
ATTN: Public Comments

Dear Lt. Governor Roberts,

I am writing today on behalf of the Rhode Island Health Center Association (RIHCA) to thank you and your office for managing the Healthy Rhode Island initiative, and to offer comments on the draft State Healthcare Innovation Plan (SHIP). As you know, there are many exciting programs, projects and initiatives in Rhode Island that seek to improve the health of Rhode Islanders. Your leadership has been crucial to the statewide efforts to implement health reform in Rhode Island, and to move forward many important conversations regarding healthcare in Rhode Island.

RIHCA represents Rhode Island's nine community health centers, which include eight federally qualified health centers (FQHCs) and one island-based health center, with twenty-nine locations throughout the state. In addition, one community mental health organization, the Providence Center, is an associate member of RIHCA.

In Rhode Island, where there are no state or county operated health departments with primary care services, the community health centers serve as the de facto public health primary care delivery system for the state. Unfortunately, the language in the draft SHIP does not fully reflect the role of the community health centers in Rhode Island, and some of the data is outdated or incorrect. We hope that you will consider using some of the information provided here to describe the community health centers in the final draft of the SHIP.

In 2012, Rhode Island's FQHCs saw 134,905 patients; over 13% of Rhode Islanders get their primary medical, behavioral health and dental care at a community health center. Nearly half of FQHC patients are publicly insured (40% Medicaid; 7% Medicare); 32% of patients are uninsured and 19% of patients are privately insured. Complete 2012 data for Rhode Island's FQHCs, including center by center reports, can be found at http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&state=RI#glist.

Rhode Island's community health centers are on the forefront of innovations in the delivery of high quality primary medical, dental and behavioral health care. 100% of community health centers in Rhode Island have adopted electronic medical records. Seven FQHCs participate in CSI, and all eight are on the path to be recognized by NCQA as patient-centered medical homes by the end of 2014. Of the eight FQHCs, five are recognized by NCQA as level 3 patient centered medical

homes, and two more have applications pending; many of these FQHCs operate more than one location.

General comments

The SHIP properly notes that there are both many opportunities for change, as well as much innovation that is currently underway in the Rhode Island health delivery system. It is an ambitious description and plan, in a state where we are ambitious, and have a robust history of innovation. It appears that much of the plan is an inventory of our current healthcare system and system innovations currently being implemented or planned in the state. As we understand it, this iteration of the state health innovation plan is intended as an end product of the substantial planning process undertaken this past year. When the time to apply for future funding approaches, we understand that the state intends to seek funding to implement specific parts of this plan. That will be an important opportunity to further focus efforts to drive statewide innovation.

As the state moves to the next level in this planning, there is a clear need to become more focused. It is our hope that the state would take the opportunity to truly innovate around the integration of behavioral health and primary medical care. What follows are some brief over all comments on three areas of the SHIP which we hope will be further strengthened in future iterations or applications for funding.

Behavioral healthcare

It is our hope that future innovation efforts seek strategies to drive the integration of the behavioral healthcare and primary medical care systems. Integration, not co-location, is the key to success here. Co-location is a possible first step, but describes what is currently happening in some Rhode Island practices. Rhode Island is ready to take the next steps, to pool the already available resources in the delivery system, and figure out how to best distribute them in a highly functioning, integrated and patient-centered way. This may result in more than one model based on varied patient populations and needs.

The Role of Patients

The SHIP is a great opportunity to drive some truly patient-centered innovation. The state should take every opportunity possible to engage patients in designing and implementing innovations. The language in the draft SHIP could be strengthened by spending more time discussing patients as active participants in their health care, and could put the patients at the center of innovation and redesign of the health care system. Some of the discussion in the SHIP around "patient responsibility" seems that it might be focused on financial consequences if a patient does not follow provider recommendations for treatment. While financial incentives are one way to drive reform of systems all around, a truly patient-centered system would be developed around the needs of patients and involve

patients in the design. This seems to echo some of the conversation around patient "compliance" or "adherence" to prescribed medical treatments. *See, e.g.,* Dr. Danielle Ofri's blog entry in the *New York Times* "Well" blog, "When the Patient is Noncompliant," Nov. 15, 2012. Patients' lives are complicated, and decision making, treatment decisions, and indeed system design all need to take into account patient priorities, needs and values in order to put the patient at the center of the patient centered medical home. Further involvement of patients in the design and implementation will only strengthen the innovation we are able to accomplish.

Community Health Teams and Community Health Workers

Community health teams should be extensions of patient centered medical homes. The teams might and should have satellite locations and be developed in close collaboration with community organizations, but the connection to the primary care home must be strong. If these teams are organized outside the primary care home there is a risk that the connections will be difficult to establish and maintain. In addition, every primary care medical home has as part of its design certain members of its team that serve as health navigators, nurse care managers, health coaches or other types of links between the community and health care system. To situate community health teams outside the medical home would result in a redundant, parallel system of health navigators, care managers, and patient advocates. We should use resources to extend and complement current teams that already exist inside medical homes, and to help them establish and maintain strong ties with community organizations in their areas.

Community health workers are often valued members of patient centered medical home teams, and function as valued team members inside and outside the medical office. We should not require licensure for community health workers, and it is our fervent hope that suggestions to the contrary be removed from the SHIP. Community health workers serve as bridges between the healthcare system and the community. They do not provide health care. Job-specific training and experience requirements are best managed by employers, and do not require licensure. Additionally, licensure would impede the flexibility required for these teams to be successful even before community health teams have been fully defined or tested in Rhode Island.

Thank you once again for the opportunity to comment on the draft SHIP. We look forward to continuing to work with the state as we move forward on these and other innovations in Rhode Island's healthcare delivery system.

Sincerely,

Jane A. Hayward

Jane A. Hayward
President and CEO

Leslie N. Wood
Senior Director
State Advocacy

PhRMA

Governor Elizabeth Roberts
Office of Lt. Governor
State House Room 116
Providence, RI 02903
ATTN: Public Comments

Dear Governor Roberts,

The Pharmaceutical Research and Manufacturers of America ("PhRMA") is pleased to submit comments on the draft of Rhode Island's State Healthcare Innovation Plan. PhRMA is a voluntary nonprofit organization representing the country's leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives. PhRMA companies are leading the way in the search for cures.

As Rhode Island convenes a stakeholder coalition to develop accountable care strategies and structure, PhRMA encourages the State to consider the following recommendations that support patient access, quality improvement, and innovation:

- Rhode Island should support choice and competition among health plans and providers.
- As the State develops governance for ac countable care organizations (ACOs) and alternative payment models (APMs), the process should be guided by meaningful input from patients, practicing physicians, and other stakeholders with relevant clinical expertise. For example, APM development should be guided by input from physicians practicing in relevant treatment areas and specialties. To the extent possible, one or more patient representatives should also be involved in the development of APMs. In addition, ACO governance should include one or more patient representatives.
- The Rhode Island Care Transformation and Innovation Center (RICTIC) and stakeholder coalition should ensure robust quality measure sets for ACOs that include, where possible, measures of clinical outcomes – recognizing intermediate health outcomes, patient reported outcomes, quality-of-life, and functional status as types of health outcomes. ACOs' should demonstrate that financial incentives for cost containment are balanced by measures of health outcomes. Measures should be reassessed on a regular basis to identify new or remaining gaps and to ensure that measures are maintained to keep pace with changes in technology and clinical practice. In addition, ACOs and their Rhode Island payers should work to add quality measures for clinical conditions where financial incentives are not balanced by quality measures, including identifying endorsed measures that can fill gaps and developing new measures where currently endorsed measures do not exist.

Pharmaceutical Research and Manufacturers of America

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- Rhode Island should ensure that ACOs have incentives to manage the total cost of care on a system-wide basis, rather than silo the cost of various products and services. ACOs should demonstrate the ability to manage the cost of care and have in place the necessary Health information technology to do so.

- ACOs should promote delivery of treatments and services recognized as the standard of care, as described by tools such as clinical guidelines, compendia, and other elements of evidence-based medicine.

- ACOs and APMs should give physicians and patients flexibility in choice of treatment and services, and should preserve and respect informed, shared decision-making by patients and physicians among available treatment options in recognition of heterogeneity among patients. Patients should be given information to support choice of ACO including the ACO's network of providers and any cost-sharing differences between ACOs. Physicians should also give patients information needed for high quality shared decision-making, and patients should have access to a timely, transparent and affordable exception and appeals process.

- If ACOs conduct assessments of novel treatments, they should provide transparency and independent review. Pharmacy and Therapeutics committees involved in making assessments of new medicines or medical technologies should consist pri marily of practicing physicians and pharmacists, come from a range of specialties, meet regularly, make their assessment criteria clear, base clinical decisions on the strength of scientific evidence, standards of practice and treatment guidelines, and account for heterogeneity among patients.

- Rhode Island Medicaid should rigorously evaluate alternative payment models within two years of development

- ACOs should promote comprehensive medication management (CMM) as the standard of care. CMM should include assessing each patient's medications for appropriateness, effectiveness, safety, and ability to be taken as intended; developing a care plan that addresses any medication problems; follow-up evaluation of the patient to ensure outcomes are achieved; and communication with the patient's health care provider.

Thank you very much for the opportunity to comment on Rhode Island's draft Healthcare Innovation Plan. We look forward to the opportunity to work with the State as it convenes its stakeholder coalition to address accountable care strategies, and we respectfully ask that representatives from our industry are included in these discussions. Please contact me, if you have any questions regarding these comments.

Sincerely,

Leslie N. Wood

Dan Meuse <dmeuse@ltgov.state.ri.us>

Healthcare Innovation Plan Comments

Rhode Island ACLU <riaclu@riaclu.org> Tue, Nov 26, 2013 at 9:26 AM
To: shipcomments@ltgov.state.ri.us

Dear Lt. Governor Roberts:

At this time, the ACLU of RI would like to offer two comments on your office's draft Healthcare Innovation Plan.

1. On Page 58, the plan refers to potentially expanding the reach and use of the APCD. When Department of Health regulations were being proposed on the implementation of the APCD, the ACLU raised a number of privacy and confidentiality concerns and urged a number of amendments to the rules. While some changes were made, the ACLU still has a number of concerns about the database's inadequate protection of patient privacy. We believe that if any efforts are made to expand the use of the database, it is critical that privacy issues be reexamined and additional privacy safeguards be added, and that any plan recognize that need.

2. On Page 62, the draft plan supports requiring payers and employers to complete "Personal Health Risk Assessments" in order "to help residents understand and address their [health] risks." The ACLU believes that any attempt to mandate such assessments is unduly invasive and raises significant issues under state and federal anti-discrimination laws. We recognize the value of these assessments, but we do not believe their completion can be mandated without raising serious policy and legal concerns. We urge that this recommendation be eliminated.

Thank you for your attention to our views.

--
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COMMENTS FROM AARP RHODE ISLAND
By Deanna Casey, Associate Director, Advocacy
dcasey@aarp.org

SUBMITTED NOVEMBER 25, 2013

AARP recognizes that Rhode Island's plan is building on a system of managed care that it has been developing for a number of years. The SIM proposal builds on reforming an existing system that has been active for many years and it will rely on an expansion of what it is currently doing.

Rhode Island's plan has the potential to work well for consumers and deliver more coordinated, less costly care. Again, AARP congratulates the state for wanting to move in the right direction. However, the issues are always found in the details and it is still early to comment specifically on details that have not yet been well-developed. It's important to continue to stress some very important principles that Rhode Island should maintain awareness of as they continue the design of these programs.

The comments below are made at a high level and present some important themes in the continued development of the SIM proposal:

Consumer Involvement

It is vitally important that there be organized and respected consumer involvement in the design process and in the implementation phases of the SIM plan. The inclusion of an active consumer advisory council is a good first step but in addition, we recommend that there be strong and active consumer representation on most of the plan design committees.

Consumers should have access to active participation at all strategic meetings, not just at their own advisory committee. The question of how any design decisions will impact consumers should be an uppermost concern. AARP supports consumer involvement during the initial phases of plan implementation and on key advisory committees during the operational stages of the implementation.

Continuity of Care and Individualized Plan of Care

Whether or not the plans end up instituting voluntary enrollment, AARP believes it is vital that sufficient attention is directed to individuals who are transitioning into a new delivery system and/or to a new primary care physician/new providers. If enrollment in a plan results in a change of primary care physician, AARP urges a face-to-face assessment of the needs with the new participant. Telephonic engagement could work for a young, healthy population, but for individuals with more complex needs, health plans must get to know first-hand the needs of these individuals. If the state wants to achieve the goal of better care with lower costs, it is essential that plans and providers understand not only the health needs of plan participants, but also the functional and other adult daily living needs.

AARP believes that plans need to engage not only with their new members, but also with the support systems they have that can help achieve both individual and state plan goals. This means, at a minimum, an initial face-to-face engagement with the individual and support system in developing a plan of care for the health and well-being of the individual. This may not apply to all individuals, but it should become engrained as standard procedure for assessing need, developing a plan and ensuring involvement by stakeholders, such as family caregivers and others who can assist in implementing

the plan of care.

Monitoring Service Delivery and Care Transitions

AARP feels strongly that the plan, medical home, ACO or other entity have robust methods for monitoring the health and well-being of all program participants. We recommend the development of a determined plan on frequency of direct contact with the plan participant that should be included in any plan of care. Often health plans know of a member's hospitalization after it occurs. While one cannot prevent every acute care need, we encourage developing a care system with a built-in expectation that there is sufficient involvement with the plan participant for avoiding potential acute care occurrences. Additionally, if a plan participant is hospitalized, there must be clear accountability on what entity will be responsible for an effective transition back to the home or to a rehab facility. Care transitions need to be closely monitored and plans held accountable for ensuring the best outcome for the consumer. This is clearly one area that needs to be monitored, measured, rewarded or penalized for performance.

Data and Performance Benchmarks

Health plans and other coordinating entities are becoming increasingly familiar with increased demands for data on both financial and care benchmarks. AARP is very concerned that plans not be given financial incentives to withhold care which has been done for many years in many states. Data must be collected and benchmarks set to reward plans and other coordinating entities based on health outcomes for the consumers they serve. AARP opposes any payment system that monetarily rewards plans solely on a per member per month basis. That system inevitably leads to withholding care and/or denials of legitimate claims. AARP urges the use of best practices methodologies that reward plans for specific performance and to consider penalizing plans that do not meet accepted performance standards. This can be approached in different ways, but plans should understand that there are defined indicators that can reveal whether defined outcomes are being achieved.

To: Office of the Lt. Governor
State House Room 116
Providence, RI 02903
ATTN: Public Comments
(also emailed to shipcomments@ltgov.state.ri.us)

November 25, 2013

From: Al Kurose, M.D., FACP
President and CEO, Coastal Medical

Re: **Public Comment on the Draft State Health Innovation Plan**

Introduction

I applaud the collaborative process that Healthy Rhode Island has used to prepare the State Healthcare Innovation Plan (SHIP). Our small state is already a national leader in healthcare reform. Coastal Medical is at the forefront of many of the initiatives underway here. A successful State Innovation Model (SIM) application could be a powerful catalyst for healthcare delivery system transformation that would benefit all Rhode Islanders.

Leadership:

Leadership will be a key success factor in the effort to accomplish delivery system transformation and payment reform in Rhode Island. The call for a stakeholder coalition to develop accountable care strategies and structures is a move in the right direction. The successful experience of CSI-RI has demonstrated the value of bringing together payers, primary care practices, and employers with OHIC as convener. However, a successful accountable care coalition will need to address analytic, financial, and strategic complexities that go well beyond the challenge of Patient Centered Medical Home Practice transformation. The proposed accountable care coalition will therefore require more participation of stakeholders with knowledge and experience relevant to these complexities. This will mean bringing in more business leaders with specialized expertise from payer, provider, and employer organizations to work side by side with physician and administrative leaders already active in collaborative healthcare leadership across the state.

Stakeholders

Inclusion of all types of providers should be the ultimate goal of the accountable care coalition. However, I believe the work should begin first with primary care providers, hospitals, payers, and employers. In this manner, the coalition could design and implement foundational constructs without an overwhelming degree of complexity at the outset. The coalition could then add different types of providers in waves, perhaps bringing in behavioral health providers and medical subspecialists as logical choices for the next group of participants.

Core Competencies:

All stakeholders in the process of delivery system transformation and payment reform should acknowledge at the outset that competency in data collection and analysis with regard to clinical quality, patient experience, and cost performance is crucial. Payers and providers of all types

will have to invest in human resources and technology. Some aspects of data collection and analysis can be "centralized," but the identification of opportunity in such data, and the design and implementation of programs to improve care and reduce costs will be *unique challenges for each organization.* Acquiring core competency in advanced data collection and analytics will be a "heavy lift" for payers and providers alike. We should acknowledge this up front.

Statewide Data Aggregation and Analytic Tools

There is an opportunity for state government to support and drive delivery system transformation and payment reform through centralized reporting of clinical and financial data. However, I believe the SHIP needs more clarity of focus about what this really means. Physician practices, hospitals, and other providers engaged in accountable care will need detailed total cost of care reports and utilization reports based on claims data by payer in as close to real time as possible. The provision of such reporting in real time has not been part of past descriptions of the goals for the APCD. Provider entities will also need clinical quality reports derived by analysis of a composite of claims-based and EMR-generated data about both test results and services rendered to patients. This type of reporting will require highly complex interactions amongst the reporting entity, each payer, and a diverse spectrum of providers all with differing health IT sophistication and using different EMR's. Coastal's experience to date in developing these capabilities internally suggests that a large investment of time and money will be required to accomplish these competencies at a system level.

Aggregation of Providers To Assess Performance and Calculate Payment

The SHIP does not address in detail the reasons that providers need to aggregate into groups to execute accountable care, nor does it speak to some of the challenges inherent in implementing such aggregation. Issues relevant to aggregation of providers include:

- Performance measurement re: clinical quality, patient experience, and cost performance require large "sample sizes" of patients to be statistically valid.
- Since cost performance in accountable care is likely to be measured and paid for by each payer separately, it becomes even more difficult to aggregate a sufficient number of providers to create a single-payer population of patients that is large enough to make meaningful assessments of cost performance. Most experts estimate that a population of at least 5,000 (and preferably 10,000) patients is needed to implement accountable care. With 88 physicians, Coastal has an "original" Medicare population of about 10,000 patients. These figures convey a sense of the number of physicians one needs to create a single-payer population of sufficient size to implement accountable care.
- Aggregated providers must agree to "sink or swim together" regarding their performance on clinical quality, patient experience, and cost. For such a construct to make any sense, these aggregated providers need shared mechanisms for measurement and reporting, care coordination, quality improvement, and implementation of new clinical initiatives.
- Even with centralized reporting from the state, providers will still need a significant shared infrastructure to transform care and succeed under performance based payment models.

Conclusion

Significant leadership, consultative expertise, IT support, working capital, and performance incentives will be minimum requirements to drive the aggregation of providers and the creation of infrastructure needed to implement accountable care across Rhode Island. The Rhode Island Transformation and Innovation Center could potentially meet many of these needs.

The notion of seeking out expertise in transforming the healthcare delivery system of an entire state is somewhat problematic, because there is no clear precedent for meeting this challenge and there is no such expertise for us to call upon. In Coastal's work to transform healthcare delivery and payment models, we have taken advantage of collaborative opportunities wherever we can find them, we have studied the best practices of others and taken away pieces that work for us, and we have shared best practices internally across our offices. At times, we have also simply experimented with change based on our own intuition and experience, and worked by trial and error to figure out how best to serve our patients. Perhaps similar processes might be useful in execution of the SHIP.

A successful SIM application could bring a once-in-a-generation opportunity to transform healthcare in Rhode Island. Coastal is eager to assist finalization of the SHIP in any way possible.

Respectfully submitted,
Al Kurose
11/25/13

Hasbro Children's Hospital

The Pediatric Division of Rhode Island Hospital

A Lifespan Partner

General Pediatrics &
Community Health

Potter Suite 200
593 Eddy Street
Providence, RI 02903

Patient Appointments
Tel 401 444-3149
Fax 401 444-3870

Academic Office
Tel 401 444-8531
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Patrick M. Vivier, MD, PhD
Associate Professor of Pediatrics
Director

Robert T. Burke, MD, MPH

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Natalia Golova, MD

Shuba Kamath, MD

Chandan N. Lakhlani, MD

Carol T. Lewis, MD

Sandra J. Musial, MD

Adam D. Pallant, MD, PhD

Randal M. Rockney, MD

Delma-Jean Watts, MD

The Honorable Elizabeth Roberts
Lieutenant Governor of Rhode Island
82 Smith Street
Providence, RI 02903-1105

Dear Ms. Roberts:

It is with great concern that I write about the SHIP draft.

The most glaring omission is the sparse discussion of children. It is astounding that the document would neglect nearly 25% of Rhode Island's population. Children have specific needs regarding health that differ greatly from adults and are not "little adults" with little needs. Investment in children's health has shown to have the most return.

My second concern and more specific is directed at Community Health Workers, page 34, item 12:

Despite the successful program at the Rhode Island Department of Health, in the marketplace that is considering new forms of value-based care, the definition of "Community Health Worker" remains unclear. Furthermore, awareness of the existence of this specialty and function is low among providers.

This is not entirely true. There are certainly core agreed upon characteristics of Community Health Workers (CHW). I see the benefits of CHW as director of Hasbro Children's Hospital Refugee Health Program and also Fostering Health Program (children in foster care) of CHW. Is it cheaper to have CHW instruct these families in a linguistically and culturally appropriate manner or have the children end up in the emergency room? Both refugees and foster children are populations that have very specific and potentially "expensive" health needs and difficulty accessing health care. In fact, in one study involving 50% of our refugee CHW we documented over 800 encounters on behalf of patients over 1 year that involved access to health care and preventative services/education by CHW. These were all uncompensated calls. Those of us who work with high –risk, medically costly populations are very much aware of the value-based care the CHW provide. Currently, they perform their services without compensation, which is not only unfair, it is not sustainable.

Thank you for considering more focus on health needs of our state's children and reconsidering your statement on CHW.

Sincerely,

Carol Lewis, MD
Director Refugee Health Program
Fostering Health Program
Hasbro Children's Hospital Primary Care
Associate Professor of Pediatrics (Clinical)
Alpert Medical School of Brown University

THE
UNIVERSITY
OF RHODE ISLAND
COLLEGE OF
NURSING

THINK BIG WE DO℠

November 24, 2013

Office of the Lt. Governor
State House Rm 116

Providence, RI 02903

ATTN: Public Comments

Dear Lt. Governor Roberts:

Thank you for the opportunity to comment on the RI State Healthcare Innovation Plan. As a practicing nurse practitioner and professor, I take the role and the value of the nurse practitioner very seriously, as I know you do. At present, RI still has significant barriers to practice, primarily through the credentialing policies of the third party payers in RI. Allowing NP's to work to their full practice authority will greatly increase the access to care to the 56,000 presently medically uninsured citizens, who will be newly credentialed through the RI Health Exchange.

Please find attached my comments to the Healthcare Innovation Plan document. I appreciate your continued support of nurse practitioner practice and look forward to assisting you and your staff in putting forth a plan that will insure better access to cost-effective health care for individuals and for populations in Rhode Island.

Please feel free to contact me with any questions or for further comment.

Sincerely,

Denise Coppa

Denise Coppa, PhD, RNP
Coordinator
Family Nurse Practitioner Program
President
Nurse Practitioner Alliance of RI
dcoppa@mail.uri.edu

NURSE PRACTITIONER ALLIANCE OF RHODE ISLAND
224 Cole Dr.
N.Kingstown, RI 02852

RI'S STATE HEALTHCARE INNOVATION PLAN
COMMENTS

The Nurse Practitioner Alliance of RI (NPARI) applauds the three aims of the innovation plan as proposed in the Lt. Governor's November 6, 2013 draft. As the professional representative group for the **819 licensed nurse practitioners** (NPs) in RI, NPARI agrees that: providing better health care for individuals and populations while reducing per capita costs can serve as a model for changing the health care system in RI in a positive, more accountable and organized way. It is well documented that NP's have demonstrated consistently delivered cost-effective, high quality care in the United States since 1965 (AANP, 2013). It is estimated that 56,000 RI citizens who presently have no health insurance, will obtain insurance under the Affordable Care Act (ACA), once the Health Source RI is fully operational (Kaiser Foundation, July, 2013). Of that number, 38,000 will be added through the Medicaid expansion. This dramatic increase in the number of patients needing health care will place an undo burden on the health care system in RI, unless all barriers to the utilization of licensed NP's are removed. The primary barrier to practice in RI is the limitation placed on NP practice by the third party payers.

"Specific comments on care transformation and innovation center structure"

The alliance supports the creation of "Patient Centered Medical Homes" with the unrestricted care provided by Nurse Practitioners. While the document being reviewed does , "...encourage fair treatment of health care providers..." and the to "...expand and improve the primary care infrastructure." (RI State Health Care Innovation Plan, 2013, p. 21), this cannot be accomplished without the inclusion of all providers whose practice authority endorses their rights to function as primary care providers. Certified nurse practitioners (CNP's) licensed to practice in RI, no longer, by law, must practice under physician supervision (Nurse Practice Act, 2013), however credentialing agreements for third party payers doing business in RI continue to require this relationship. By adopting provider neutral language throughout this proposed plan, it helps to endorse the ability for NPs to work as autonomous members of the health care team. In addition to the RI Nurse Practice Act, the Patient Protection and Affordable Care Act prohibits discrimination by third party payers of all health care providers. The following is a section from the PPACA:

New § 2706(a) of Public Health Service Act, created by § 1201 of Patient
> Protection and Affordable Care Act ("PPACA")
> – "A group health plan and a health insurance issuer offering group or individual
> health insurance coverage shall not discriminate with respect to participation

T> the plan or coverage against any health care provider who is acting within the
> scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer
> contract with any health care provider willing to abide by the terms and conditions
> for participation established by the plan or issuer. Nothing in this section shall be
> construed as preventing a group health plan, a health insurance issuer, or the
> Secretary from establishing varying reimbursement rates based on quality or
> performance measures." 42 U.S.C. §300gg-5(a).

This mandate should be considered by the Lt. Governor's office before finalizing the language of the "Healthcare Innovation Plan".

"Targets for transition to value based care..."

Phasing in NP's as primary care providers of record with patient panels over a 5 year period would set the standard so that all health care practices, both public and private, could add another health care provider skilled in the diagnosis and management of preventive, acute and chronic health care issues. Participation in individual and group patient appointments to provide oversight of chronic diseases, for instance, could serve as a viable model where value based patient outcome measurement could be easily undertaken. NP's have also demonstrated the abilities to assist in positive health care transitions while decreasing numbers of emergency department visits and hospitalizations for clients in long term care facilities (Newhouse, 2011; Robert Wood Johnson Foundation, 2012).

As noted by the Robert Wood Johnson Foundation (2012), health care to the uninsured, isolated and medically vulnerable is grossly under recognized in this country. This coupled with the fact that fewer than ever physicians enter primary care residencies, points to the need that NP's should be recognized as primary health care providers, working to their full practice authority in RI to make the Healthcare Innovation Plan a success.
References submitted by request.

Respectfully submitted,

Denise Coppa

Denise Coppa, PhD, RNP
President
Nurse Practitioner Alliance of RI

Office of the Lt. Governor
State House Room 116
Providence, RI, 02903
ATTN: Public Comments

RE: Rhode Island's State Healthcare Innovation Plan

November 25th, 2013

Dear Lt. Governor Roberts,

Thank you for the opportunity to comment on the State Healthcare Innovation Plan. It is clear from this report that the professionals and stakeholders assembled for this project have done a commendable job assembling information on all the various pieces that will make up a more patient centered, effective health care system for Rhode Islanders.

The Rhode Island State Nurses Association, as the professional association representing the nurses of RI is committed to continue to be active in the work of the committee and various work groups. We are excited about the opportunity to positively affect the health of Rhode Islanders. Please find our comments which we are hopeful will be incorporated as the state moves forward with this innovative plan.

- The Workstream taskforce on Workforce and Practice Transformation recommended that the term "physician extender" be eliminated. The term "health care provider" would allow for each provider to work within the scope of practice and education.
- Language around primary care physicians should be changed to reflect the importance of advanced practice nurses in the provision of high quality primary care. This is important in all areas but of particular importance in the medical home model.

- The plan calls for growing the PCMH model, please ensure that nurse care coordination is funded and incentivized.
- Lastly, we would suggest, as other stakeholders and advocates have expressed, that the plan include a robust attention to addressing the social determinants of health in order to focus on primary prevention.

Again, we thank you for this opportunity to participate in this exciting work.

Very best regards,

Chris Gadbois, MSN, RN-BC, CDDN, PHCNS-BC
President, Rhode Island State Nurses Association
150 Washington St, Providence, RI 02903

Healthcentric Advisors
Advancing Healthcare Quality | Empowering People

November 22, 2013

Lieutenant Governor Elizabeth Roberts
State of Rhode Island
Attention: SHIP Public Comments
State House Room 116
Providence, RI 02903

Re: Public Comments/Recommendations on the Draft State Health Care Innovation Plan (SHIP)

Dear Lieutenant Governor:

On behalf of Healthcentric Advisors I am pleased to submit my organization's public comments and recommendations regarding the draft of the State Health Care Innovation Plan released on November 6, 2013. The draft SHIP, as presented, is an excellent roadmap for how Rhode Island needs to continue its transition to a high quality, high value, performance-based and patient-focused healthcare delivery system.

Our submission has a twofold purpose. First, it is our intention to provide meaningful and objective commentary and contributions towards the final version of the SHIP. Secondly, we wish to share additional information regarding other important healthcare reform efforts and initiatives that were not referenced in the draft SHIP or would benefit from a more complete description or explanation. In particular, the SHIP failed to fully describe the healthcare reform efforts, initiatives and programs of Healthcentric Advisors in the areas of (1) Electronic Health Record adoption and optimization; (2) physician practice transformation (i.e. PCMH/team-based care); (3) safe care transitions/readmissions reduction; and (4) HIT workforce job training.

Assuming acceptance by the Centers for Medicare and Medicaid Services and funding of a subsequent application by the State of Rhode Island, Healthcentric Advisors stands ready to assist the State in the implementation of the final SHIP.

We look forward to sharing our experience and subject matter expertise with the State of Rhode Island in the following areas:

1. Project Management - we have over 18 years of experience developing and deploying complex healthcare quality improvement and patient safety initiatives, engagements and programs.
2. Serving as a Neutral Convener – we are viewed by healthcare stakeholders from all settings as one of the State's key neutral convener organizations for education, technical assistance and policy development.
3. Contract Administration – we have received outstanding reviews for our administration of over $53 million in federal and state contracts over the past 10 years.
4. Educational Expertise – we have solid corporate experience in providing meaningful and effective education in collaboratives and large group environments as well as individual provider hands-on technical assistance and guidance.
5. Physician and Ambulatory Practice Transformation Services – we have a long history in Rhode Island providing physician practice transformation advisory services including the full range of EHR implementation/optimization, PCMH and team care assistance.
6. Care Transitions/Readmissions Reduction Efforts – we are a nationally recognized subject matter expert in this area.
7. Healthcare Quality Improvement knowledge – we have solid experience providing quality improvement technical assistance in all settings, from outpatient to acute-care to long-term care.
8. Patient Engagement Knowledge – through our many quality improvement contracts and engagements we have developed expertise and skill sets in the areas of patient activation and engagement.

Thank you for this opportunity to comment on an excellent draft SHIP. We look forward to continuing to partner with you and your staff on future healthcare delivery reform initiatives.

Respectfully yours,

H. John Keimig, MHA, FACHE
President and Chief Executive Officer

Current SHIP Language	Healthcentric Advisors' Comment
Location: Chapter 2 / Page 14 Description of Healthcentric Advisors under "Other Important Members of the Healthcare Community"	*Request:* *Please describe Healthcentric Advisors in the following manner which is a more accurate representation of our mission and current role in the state's healthcare delivery system:* With 18 years of experience, Healthcentric Advisors is a local nonprofit organization providing healthcare quality improvement patient safety technical assistance, analytical, educational, research, and project management services. The organization has a history of working with and for state and federal government agencies, healthcare providers, research organizations and other national and community entities. Healthcentric Advisors is known for its subject matter expertise in physician office practice transformation, care transitions and readmissions reduction, and making providers' quality data meaningful and actionable. A principal role for Healthcentric Advisors is serving as the Medicare Quality Improvement Organization contractor for the State of Rhode Island. The organization is viewed as one of the State's neutral conveners by assisting healthcare providers in all settings to successfully implement new quality improvement initiatives. Its voluntary board of directors has representation from the healthcare, business, and consumer communities.
Location: Chapter 2 / Page 16/Paragraph 2 Description of the DOH HIT survey	*Suggest editing paragraph 2 on page 16 in the SHIP, with the following paragraph to provide the reader with the context in which the physician HIT survey is administered:* HEALTH's Healthcare Quality Reporting Program is a legislatively-mandated public reporting program that is led by HEALTH's contractor, Healthcentric Advisors. The program surveys physicians annually about their EMR and e-prescribing adoption. In 2013, the program administered the survey to 3,799 physicians licensed in Rhode Island, in active practice, and located in Rhode Island, Connecticut or Massachusetts. The response rate was 62.3% (n=2,367) (HEALTH, 2013). The following table shows current trends for EHR adoption and use, as well as e-prescribing adoption.
Location: Chapter 2 / Page 16 & 17 Electronic Health Record (EHR) Adoption	*Recommend adding the following language to the SHIP, to reflect additional EHR provider activities within the RI healthcare landscape:* Healthcentric Advisors has a long history working with providers to transition from paper records, optimize their EHRs and quality data reporting workflows, and make data actionable and impactful for clinical interventions. As the Medicare Quality Improvement Organization for the State of Rhode Island, Healthcentric Advisors began working with some of the first practices in the state to implement EHRs and integrate them into existing clinical processes, within *The Doctors' Office Quality Information Technology* (DOQ-IT) program. Two additional EHR / Health IT quality improvement contracts for physician offices have followed DOQ-IT, supporting those early adopters with advanced quality endeavors as well as meeting the needs of practices struggling with the pace of change. In 2008, work focused on partnering with physicians to

Current SHIP Language	Healthcentric Advisors' Comment
	improve preventive health outcomes by helping them interpret and take action on clinical quality metrics via consistent data capture, interpretive analytics, and electronic clinical decision supports. Healthcentric Advisors most recent physician office quality contract which began in 2012, *Improving the Health for Populations and Communities* focuses on advanced principles of EHR optimization, care team transformation, and patient engagement. Examples include: • Harmonizing project quality improvement measures including: o Meaningful Use o Physician Quality Reporting System (PQRS) o Healthy People 2020 o The ABCS of the Million Hearts Campaign o NCQA PCMH Standards • Capturing, reporting and analyzing EHR data to identify trends and outcomes, redesigning workflows • Promoting peer-networking, direct electronic messaging and provider compacts between PCPs and specialists to support patient co-management • Promotion of EHR utilization for patient education tools and visit summaries Additionally, the organization expanded its EHR quality improvement work to support broader practice transformation, including on-site support to federally qualified health centers, helping them adopt patient-centered care teams, and take the essential, foundational steps to become Medical Homes.
Location: Chapter 2 / Page 27 Safe Transitions Program	*Recommend an addition to the current language in the SHIP to more accurately reflect the impact of the safe transitions program on the state's healthcare delivery system:* Healthcentric Advisors has been working with healthcare providers and other community organizations since 2008 to improve transitions of care for Rhode Islanders and reduce avoidable hospital readmissions through education, research, and technical assistance. Healthcentric Advisors' Safe Transitions program provides support to individual providers who are implementing evidence-based interventions to reduce hospital readmissions and the Safe Transitions program has also formed regional coalitions that work to identify opportunities to improve care transitions in their community. The program has also established setting-specific Best Practice Measures, creating measurable, communitywide standards for patient activation and cross-setting communication. One of Rhode Island's five care transitions community coalitions, Washington County was recognized by CMS for achieving one of top Relative Improvement Rate (RIR) for Readmissions per 1,000 Medicare FFS Beneficiaries. In late 2013, Healthcentric Advisors started expanding the Safe Transition effort, with a special EOHHS-funded learning collaborative that will explore communication opportunities between hospitals and community providers at the time of discharge.
Location: Chapter 2 / Page 29 Federally Supported Healthcare Information Efforts in Rhode Island	*Recommend including the following federally supported HIT efforts into SHIP:*

Current SHIP Language	Healthcentric Advisors' Comment
	U.S. Dept. of Labor Community-Based Job-Training Program. From 2010-2013, the New England Institute of Technology (NEIT) and Healthcentric Advisors received a $2.8 million grant as part of the U.S. Dept. of Labor Community-Based Job-Training program. The goal was to maximize the expertise of Rhode Island healthcare workers with state-of-the-art training in EHRs and prepare healthcare workers for the federally-mandated 2014 deadline to institute EHRs in all sectors of the industry. Designed to meet the training needs of those who work in physician offices, long-term care facilities and hospitals, the program offered tuition-free classes at three different skill levels: entry, intermediate and advanced. The program also included preparation for the nationally-recognized Certified Professional Electronic Health Record (CPEHR) exam or Electronic Health Record Specialist Certification (CEHRS) exam. The grant program's Advisory Committee, made up of industry, educational and community representatives, provided input into the curriculum's design and identified upgrades needed to ensure relevant training for the students. Over 600 students participated in the program, 98% of whom were employed in healthcare. The program resulted in over 340 individuals sitting for one of the two nationally-recognized certification exams. To support a sustainable, standardized resource in the community, NEIT and Healthcentric Advisors were able develop a curriculum from this grant to build a new Health Informatics degree program for the school. NEIT allowed students enrolled in the HIT Job-Based Training courses to receive transferable college credits for the Health Informatics degree requirements.
Location: Chapter 3 / Page 31 Healthcare Challenge #3	*Comment:* The process by which patients move from hospitals to other care settings is increasingly problematic as hospitals shorten lengths of stay and as care becomes more fragmented. In general, hospital readmission and healthcare utilization rates vary substantially across geographic locations, suggesting opportunities for improvement in areas with higher observed rates, such as Rhode Island.
Location: Chapter 3 / Page 33 Healthcare Challenge #7	*Comment / Clarification:* Rhode Island has a 15-year-old legislatively-mandated Healthcare Quality Reporting Program that requires HEALTH to publish comparative information on providers' clinical quality measures and patient satisfaction, with the dual goals of informing patient decision making and driving market-side quality improvement. The program has an established stakeholder committee structure, Chaired by Dr. Fine, that prioritizes reporting topics and advises HEALTH and its contractor, Healthcentric Advisors, on the creation of the public reports available at: www.health.ri.gov/programs/healthcarequalityreporting/index.php
Location: Chapter 3 / Page 33 Healthcare Challenge # 8: There are unrealized opportunities for the healthcare system to incent higher levels of patient	*Comment:* Unrealized opportunities for patient engagement result from influences

Current SHIP Language	Healthcentric Advisors' Comment
engagement	on both sides of the patient-provider relationship. Patient activation could be stymied if healthcare consumers are unaware of this new type of delivery system. However, patients have a number of other factors impacting their ability to proactively self-manage their healthcare. These include: patient health literacy, cultural norms and biases, age, and other social impacts. Providers too, play a key role in the success of their patient's level of engagement. Many providers practicing in the traditional, fee-for-service model, do not have a clear understanding or are resistant to moving to a shared decision making model with their patients. Further, while they may be motivated to activate their patients, providers may not have the appropriate knowledge, tools and care team staff models in place to address the barriers their patients face, setting both sides up for uncertainly and insecurity.
Location: Chapter 4 / Page 36 RI's Healthcare Goals: Targets: • 30-day all-cause readmission • 30-day readmissions after hospitalization for behavioral health	*Recommendation:* We suggest the SHIP 1) replace the two readmission measures (30-day all-cause readmission and 30-day readmissions after hospitalization for behavioral health) with two measures of unplanned utilization, one for acute-care admissions and one for behavioral health admissions, and 2) expand the time period from 30 days to 90 or 180 days. *Justification:* In June 2013, Healthcentric Advisors published a commentary in the *American Journal of Managed Care*, articulating the need to shift from focusing on hospital visits and readmissions to bundled measures of unplanned care. The authors used Rhode Island data to demonstrate that readmission rates provide an incomplete picture of unplanned care and costs and may lead to unintended consequences, such as increased observation stay rates. In lieu of readmissions, we suggest that the SHIP calculate post-discharge unplanned utilization, including ED visits, hospitalizations and observation stays (as proposed in our commentary) and urgent care visits. This would allow the state to examine a more complete picture of post-discharge utilization and also to calculate bundled costs, helping to assess the SHIP's impact on the three-part aim.
Location: Chapter 4 / Page 36 Request input on selecting set of appropriate population health targets from these or other programs	*Comment:* Physicians are tasked with tracking, attesting and sustaining success for a number of clinical quality metrics, across a variety of initiatives and stakeholders. Harmonizing measures appropriate for PCPs and specialists alike and creating pathways to consolidate reporting will ease the burden on the providers and create a cohesive, foundation upon which the state can build. *Recommendation:* We suggest identifying the population health measures currently being utilized locally as a starting point for review and potential expansion. Healthcentric Advisors' is currently working with ~ 150 providers on preventive health measures and the Million Hearts Campaign *ABCS* (Aspirin Therapy, Blood Pressure Control, Cholesterol Management, and Smoking Cessation) via PQRS. Alignment with other QI initiatives (*Meaningful Use, PCMH, and Healthy People 2020*) has been demonstrated through this project. These providers and their care teams in both the PCP and cardiology community have been tracking,

Current SHIP Language	Healthcentric Advisors' Comment
	trending, and submitting data for PQRS measurement reporting for the past two years.
Location: Chapter 5 / Page 54 Request comments on the care transformation and innovation center regarding its structure and specific activities.	*Comment:* (Please see addendum 2 for detailed comments and recommendations)
Location: Chapter 5 / Page 55 Provide Technical Assistance	*Comment:* To ensure success and sustainability across the continuum of care, technical assistance for providers goes beyond primary care physicians and includes community health center staff, specialists, long-term care providers, urgent care staff, home health teams and other community-based organization staff members.
Location: Chapter 5 / Page 55 Use regulatory and purchasing powers to set contracting standards	*Recommendation:* The selected targets for the transition to value-based care should show linkage and alignment with goals # 3 and # 4 of the SHIP.
Location: Chapter 5 / Page 56 Expanding the Use of Community Health Teams	*Recommendation:* We suggest SHIP further clarify expanding the use of Community Health Teams to include details regarding ownership options, cost sharing, incentives and payment structures.
Location: Chapter 5 / Page 57 Centralized Aggregation Entity… to educate the public on the value of transparency and a centralized health information system."	*Comment:* The Centralized Aggregation Entity outlined within the SHIP suggests the opportunity to provide healthcare consumers a higher level of transparency about the quality and value of care they are currently receiving. However, sharing physician metrics on cost, quality, and outcomes at a statewide level should coincide with data support and resources at the provider level; the majority of physician offices lack the data analytic teams in place to both *interpret* quality data (whether provided internally via their EHR or from external sources) and to make it *actionable* for sustainable improvement. *Recommendation:* The SHIP should clearly identify and outline interpretive analytic resources that can be accessed by physician offices to mitigate or improve upon any aggregate, statewide metrics shared publically.
Location: Chapter 5 / Page 59 Promotion of Health Information Technology and Measurement	*Comment:* It is important to consider the other HIT measurement initiatives actively underway locally, within physician offices. Healthcentric Advisors is

Current SHIP Language	Healthcentric Advisors' Comment
	working with a number of providers to electronically track and submit PQRS reporting metrics both via claims and directly via their EHRs. The practices reporting PQRS measures with an EHR are some of the first physicians in the country, piloting this approach with CMS. Beginning in 2013, all provider practices are required to report to PQRS to either receive a payment incentive or payment adjustment for the *CMS Physician Feedback / Value-Based Payment Modifier Program*. PQRS will serve as the reporting mechanism for this program, which will begin in 2015 to provide a Medicare FFS increase or adjustment on all FFS payments (based on the *2013 reporting year*): http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRI/. The PQRS program will continue to increase harmonization of its measures to the Clinical Quality Measures (CQMs) within Stage 2 of the Meaningful Use incentive program. *Recommendation:* To ensure alignment and efficiency for physician offices and their staff, SHIP should include an environmental scan of the additional quality reporting initiatives providers are/will need to measure and report.
Location: Chapter 5 / Page 60 Workforce Development: Conduct a Workforce Assessment	*Recommendation:* Regarding the section on page 60, *Conduct a Workforce Assessment*, the writers may want to reference the existing work of the Governor's Workforce Board (GWB). In 2014, GWB will be conducting a workforce skills gap study, building off their past studies. The study will be joint effort between GWB's Healthcare Industry Partners: Healthcentric Advisors, Stepping Up, and the Hospital Association of Rhode Island.
Location: Chapter 5 / Page 61/63 Patient Engagement	*Comment:* Patient engagement is an essential piece of the puzzle for person-centered care and shared decision making. Engaging patients and their families yields better outcomes and supports the triple aim. But the root of the activated patient is found in their attitudes, beliefs, and behaviors about self-managing their health. Cultural norms, family dynamics, age, social impacts and an individual's health literacy all influence how a patient will respond to this new model of care. This transformative approach also lacks a succinct roadmap for many care providers to implement a more collaborative relationship with their patients. Additionally, providers need to identify other key members of their care teams to share in the responsibility of patient engagement. *Recommendation:* RICTIC should create training and resources for both healthcare consumers and healthcare providers, to support both parties in this new dynamic of shared decision making, taking into consideration the influences and barriers that impede patient engagement and offering tools to mitigate them.

Addendum 1

Issue Brief: Care Transitions Accomplishments

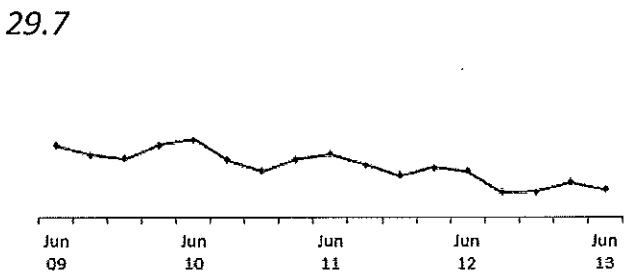
Healthcentric Advisors

A Preeminent National Leader in Care Transitions
Research, Education, Publication, Facilitation and Implementation

Since 2008, Healthcentric Advisors has successfully partnered with healthcare providers and stakeholders to improve the care, quality and costs associated with Rhode Island patients' transitions from one setting to another.

Rhode Island's Medicare readmissions rate has decreased 6.0 per 1,000 patients since January 2009.

Rhode Island Hospital Readmissions Rates per 1,000 Medicare Beneficiaries



Semi-Annual Rates

What has Healthcentric Advisors accomplished?

✓ **Healthcentric Advisors was the first in Rhode Island to introduce the concept of care transitions to providers, payors and the public.**	*Due to our leadership, expertise, and national reputation, we were one of only 14 Medicare Quality Improvement Organization (QIO) contractors to be awarded a prestigious Medicare care transitions special study in 2008.*
✓ **Our national leadership in care transitions and reducing avoidable readmissions has had a positive financial impact on Rhode Island.**	*We have brought ~$8 million in federal funding to our state to improve care transitions—and have partnered with other entities to secure additional funding state in this area.*
✓ **We were the first organization in the nation to frame care transitions as a patient safety goal.**	*The nation (CMS, other QIOs, hospitals, and other provider entities) has followed our lead, adopting this perspective; this aligns care transitions with the National Quality Strategy and three-part Aim.*
✓ **We were the only recipient of the Medicare care transitions special study to partner with two national leaders.**	*Dr. Eric Coleman (University of Colorado) and Dr. Brian Jack (Boston Medical Center) co-chaired the Healthcentric Advisors' Safe Transitions Advisory Board from 2009 until 2012, giving Advisory Board members direct access to two pre-eminent care transitions researchers.*

What has Healthcentric Advisors accomplished?

✓ **As a result of our work, Rhode Island is the only state in the country to universally adopt evidence-based care transitions best practices for hospitals and incorporate them into hospital contracting.**	*We created and facilitated the adoption of care transitions best practices throughout the state, including hospital best practices. Our best practices also include EDs, home health agencies, physician offices, nursing homes and urgent care centers.*
✓ **Our care transitions work has been recognized by state legislative and government leaders.**	*The Office of the Health Insurance Commissioner directed health plans to incorporate our care transitions practices into their hospital contracting.* *The General Assembly acknowledged our accomplishments by directing hospitals to participate in a transitions project.*
✓ **We are among the nation's leading educators and advisors in the area of care transitions and reducing avoidable hospital readmissions.**	*Locally, we lead 5 regional care transitions coalitions and a statewide learning and action network. We also provide expertise and consultation to concurrent initiatives, such as bundled payment and the Community-Based Care Transitions Program.* *Nationally, our team regularly presents at national conferences. In 2012, our accomplishments were profiled in a national Medicare Webinar.* *In 2011, we hosted a nationally-recognized Transitions Summit during which local and national care transitions leaders and experts developed a shared vision for care transitions in Rhode Island.*
✓ **We are among the nation's leading publishers of care transitions research, results, information and recommendations**	*We were the first to prove the real-world efficacy of Dr. Coleman's patient coaching, with results published in the* Archives of Internal Medicine. *Our work has been published and referenced in leading medical and healthcare journals.* *We receive frequent requests from research journals to serve as peer-reviewers for care transitions manuscripts.*
✓ **Our work has produced tangible results and solid improvement in healthcare quality and patient safety for Rhode Islanders.**	*All Rhode Island providers are now focused on care transitions. As a result of our collaboration and leadership, Medicare readmission rates are declining in Rhode Island, leading to improved patient outcomes and generating cost avoidance.*

H. John Keimig, MHA, FACHE, President & CEO
jkeimig@healthcentricadvisors.org
t 401.528.3238 | f 401.528.3210

Public Comment to: Chapter 5 / Page 54

Structure and Activities of the Proposed Rhode Island Care Transformation and Innovation Center (RICTIC)

I. Recommended Organizational Structure Attributes

- Public – private partnership where the State contracts with an existing private 501c (3) community entity to serve as an umbrella organization for the RICTIC.
- The umbrella organization would be responsible for the overall development, implementation and administration of the RICTIC.
- A *Leadership Advisory Board* (LAB) would be established to provide oversight of the RICTIC and establish its priorities and monitor its performance against goals and objectives.
- The LAB would be composed of physicians, consumers, payers, purchasers, institutional providers, state government representatives, educators and other community healthcare, social service and related organizations.
- The umbrella organization would subcontract with other organizations, agencies, and entities on an as needed basis in order to successfully achieve the goals and objectives of the RICTIC.

II. Recommended Competencies and Credentials of the RICTIC

- Track record of successfully working with providers in all settings - cross-setting and individually (hospital, nursing home, home care, community health center, and physician office settings).
- Track record of successfully administering state and federal contracts.
- Track record of successfully working with state agencies and departments.
- Trusted and experienced neutral community convener.
- Solid project management experience.
- Extensive quality improvement technical assistance experience.
- Solid analytics experience (including data aggregation, database management, outcomes reporting and interpretive analytics).
- Experience in measures development.
- Experience in administering education collaboratives and learning and action networks.
- Experience in providing EHR consulting and advisory services (readiness assessment, pre-implementation planning, implementation, and optimization).
- Staff with NCQA's *Patient Centered Medical Home Content Certification (PCMH CCE)*
- Care transitions subject matter expertise.
- Physician office and ambulatory care setting practice transformation consulting and advisory experience.
- (Proven) Knowledge of workforce development efforts.
- Research and peer-reviewed publication experience.

III. Recommended Roles and Activities of the RICTIC

- Serve as the state's central repository and hub for healthcare transformation, ACO and value-based purchasing education, knowledge, resources, and technical assistance.
- Provide large group, collaborative format learning and educational programming.
- Create and administer remote learning opportunities for providers.
- Provide customized individual technical assistance to providers on:
    - Patient Centered Medical Home
    - Expansion to Medical Neighborhoods
    - Practice Transformation
    - Care Coordination
    - Team-based Care
    - Admission/Readmission Reduction
    - EHR Optimization (*beyond* Meaningful Use)
    - Interpretive Analytics Services
    - PQRS
    - Quality Improvement Techniques and Applications
    - Patient Engagement and Activation
    - Cultural Competency
    - Health Literacy

- Serve as the principal convener of stakeholder organizations and coalitions relating to the implementation of the State Healthcare Innovation Plan.
- Provision of analytical information and interpretation for providers.
- Serve as an incubator for new models of value-based care.
- Serve as a resource for patient activation and engagement including advance care planning.
- Work with the RIQI to advance CurrentCare throughout the state

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Rhode Island Chapter

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November 19, 2013

Lt. Gov. Elizabeth Roberts
State House
Providence RI 02903

Dear Lt. Gov. Roberts,

As pediatricians and enthusiastic participants in your health care reform efforts, we are impressed by the excellent information and the health care innovations in the *HEALTHY Rhode Island [HRI]* draft now out for comment. We are impressed by the vigorous, inclusive process of planning. We have previously submitted some specific suggestions about medical homes for children (letter of 23 Sept).

However, we are still very concerned about *HEALTHY Rhode Island's* narrow focus on the problems, costs, and options for adults' medical care, with only light, late, and limited attention to children's life trajectory/ prevention issues, and to public health. We worry that *HRI* will be seen as the state's plan for health budgets, and that basic, effective and cost-effective investments beginning in infancy and continuing throughout childhood and youth will be neglected. Preventive medicine cannot truly occur once children are damaged from obesity, mental stress and myriad effects of inadequate healthcare and poverty.

While it is very important to improve the effectiveness, equity, and excessive expense of American medical care, that cannot be achieved without serious, sustained investments in healthy child development, public health, and primary prevention for everyone. In this draft of HRI, prevention is touched here and there, children are mentioned only twice, and public health only on the last page.

Rhode Island's children and youth deserve a seat at this table. The State Innovation Plan should include:

- strong support for children's medical homes (PCMH Kids), including
- robust developmental/behavioral health care and the creation of a true behavioral health system for kids,
- promoting parent and patient roles in all of our reform efforts,
- explicit support for public health integration into our primary care model and
- workforce development for these approaches.

Therefore, we recommend that the *HEALTHY Rhode Island* plan be broadened to include children's and community health needs, even if those

needs are not addressed in the same detail. We would be happy to assist with drafting.

There are some good starting points in the "6 pillars" of HRI:

> **#3. Patient/Consumer Centric.** Family centered health management is critical to humans' success. RI has built medical homes and peer parent models of kids' care that give better outcomes and lower costs. These models need solid funding.
>
> **#4/5 Transparency and Accountability** will require good population health data. Public health data seldom come from medical claims (or even from EHRs) KIDSNET is a unique RI asset, helpful for good care, and for measuring how well we reach all children with essential services.
>
> **#6 Community Assets** are the real foundation of healthy child development, and of public health. RI has shown how to help parents become part of community assets, through family centered medical homes.

A long healthy life begins at the beginning – infancy (actually before conception) – and is built and protected through the first decades by effective parents, healthy neighborhoods, good schools, and by excellent pediatric care. Rhode Island has been enlightened in its tradition of stalwart support for immunizations, for protection from lead and other hazards, for KIDSNET data, for parent engagement in medical homes, and for RIte Care.

We believe those priorities should be woven into the text of *HEALTHY Rhode Island*, or perhaps it would be even more powerful to draft a new chapter on children, primary prevention, and public health. Without that, the plan may achieve some useful innovations in adult medical care, but it won't address lifelong health, or reduce ruinous future medical costs.

We would be grateful for an opportunity to discuss these concerns directly with you and your staff.

Sincerely,

William H. Hollinshead, MD MPH, FAAP
President
American Academy of Pediatrics
Rhode Island Chapter

Public Comments

Matt Forster <bracesnewport@gmail.com> Wed, Nov 20, 2013 at 9:21 AM
To: shipcomments@ltgov.state.ri.us

To whom it may concern:
Thank you for the opportunity to voice an opinion regarding this matter.
Unfortunately, I was never asked to do so before Obamacare was mandated for all of us. Now it seems moot this show of "listening".

As a small business owner, I purchase BCBS personally for myself, wife and three kids, which is no small feat, but we were happy with our coverage. We just received notification that our premium will go up for my family $400 next year. That is a 50% increase. It will force me to shop on your exchange for a comparable policy if that exists. I have no desire to do so given the amount of personal information that needs to be reported over an unsecure and untested website and the amount of extra time I am now forced to undertake. We are busy and I do not have spare time to sit at a government office to do this in person. It saddens me that you and your staff have endorsed this change to help some people while hurting a lot of other hard working people. If given the opportunity to voice opinions before this debacle, I would have proposed different ideas to help businesses so they could create more jobs. This new policy in no way helps businesses, and I would think this state should focus on that rather than increasing entitlements and creating disincentives to work.

Once again, my government and community is failing me on a state level and I am joining the growing tide of reform in this state. Enough is enough, please get rid of this health system you are forcing on us and stop spending all this money on marketing and advertising. It is sickening.

Thanks for the opportunity to respond.

CMF

--
Dr. Matt Forster, DMD
www.ForsterOrthodontics.com

Dan Meuse <dmeuse@ltgov.state.ri.us>

Healthcare Roadmap "payment rooted in value"?

Peter Lodge <peter.lodge48@gmail.com> Tue, Nov 12, 2013 at 12:08 PM
To: shipcomments@ltgov.state.ri.us

If this plan is to be successful policy wonks such as the one who wrote the preface should be banned from any involvement in its development and implementation. Providers of services in the current 'broken plan" are painfully aware of the shortcomings and can best describe a workable framework for the future.
If on the other the unsaid goal is to create an new bureaucracy of regulators regulating regulators who deny payment for services ...slog on. By the way....what does payment rooted in value mean?

Peter J. Lodge D.M.D.
Narragansett, R.I.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Administration
DIVISION OF PLANNING
One Capitol Hill
Providence, RI 02908-5870

November 12, 2013

Lt. Governor Elizabeth Roberts
Office of the Lt. Governor
State House Room 116
Providence, RI 02903

Dear Lt. Governor Roberts:

I am writing to express my support and enthusiasm for the State Healthcare Innovation Plan (SHIP) as presented for public comment on November 6, 2013. The Division of Planning has been honored to be a part of the plan's development and I am especially delighted to see the plan's consideration and integration of the social determinants of health and non-traditional approaches to improving the health of Rhode Islanders.

The Division of Planning is ready and willing to partner with other State agencies and community-partners to increase awareness and understanding of the social determinants of health, as described on page 63 of the SHIP. It is becoming increasingly clear that the land use, transportation, housing and other decisions made at the local level have a direct impact on resident health. Through smart planning, local governments and the State can actively improve the health of Rhode Island's current and future populations, but we must first realize and understand the impacts of our decisions on health.

Also, the creation of a Healthcare Innovation Trust Fund is of particular interest to the Division of Planning, in that it could assist municipalities in funding built environment projects that will have long lasting positive impacts on the health of residents. While the common understanding of healthcare is in the provision of health services, the Healthcare Innovation Trust Fund could be used to inspire real innovation in addressing the social determinants of health and built environment impacts by funding community-based projects.

Please know how much we value continuing our work together on this valuable initiative. We look forward to collaborating with you to sustain this work in the coming years.

Sincerely,

Kevin Flynn
Associate Director
Rhode Island Division of Planning

Dan Meuse <dmeuse@ltgov.state.ri.us>

ACA

John Laiho <john-laiho@cox.net> Sun, Nov 10, 2013 at 11:50 AM
To: shipcomments@ltgov.state.ri.us

To Whom It May Concern:

I was probably one of the first people to sign up my wife and I on the exchanges. It took several hours to do so over the phone, and I needed to visit the main office in Providence to prove my identity. That being said, it was well worth my time. My wife and I will save thousands in monthly premiums due to the tax subsidies. Our current policy with BC/BS has a premium of $1315 per month. Starting in January, the premium will be $345 per month. The new policy deductibles ($2600/$5200) vs. the old plan ($1500/ $3000), will be higher as well as the maximum out of pocket expenses; the old plan ($3000/$6000) vs. the new plan($4000/$8000). In the worst case in which both of us max out, we will still save thousands of dollars. For example:

12 *$1315=$15780+$6000=$21780 old plan

12*$345=$4140+$8000=$12140 new plan Savings of $9640

While the new plan has considerable savings, how affordable would $12140 per year be if our health were to take a turn for the worse? And, how many Rhode Islanders would find this amount affordable even with tax subsidies?

I realize there are other considerations that make the ACA a vast improvement over the status quo. The elimination of pre-existing conditions and lifetime limits, raising the eligibility age of children to 26 years old, and covering preventative services to mention a few. Not to mention many who did not have health insurance will now have it.

The good news is that we are making progress. A good first step.

However, I would like to point out that my wife and I are looking forward to being eligible for Medicare in a year and a half. Yes, we will still need to purchase a gap plan from the private insurers, to cover what Medicare does not, but we will not have the exposure to large deductibles and out of pocket maximums.

Vermont is trying to implement a state Medicare program. Long term, Rhode Island should be looking to do the same. There are some states which are being dragged kicking and screaming to provide health insurance to their citizens. Rhode Island is not one of them. Like Vermont and Rhode Island, there are other states which embrace reforms, particularly in the Northeast. A regional approach to implementing single payer health insurance for the states amenable to reform should be explored. Think of our children and grandchildren avoiding the morass of the private insurance market place.

Again, a good first step setting up the RI Health Insurance Exchange. What can we do to make things better?

John Laiho

76 Hampton Way

Wakefield RI

Dan Meuse <dmeuse@ltgov.state.ri.us>

Discontent

John Romano <jrdds82@cox.net> Fri, Nov 8, 2013 at 2:33 PM
To: shipcomments@ltgov.state.ri.us

Inviting comment from those of us who have no voice seems completely disingenuous if not dishonest. This State was founded on freedom, specifically freedom of religion, yet you have somehow empowered yourselves to decide what is best with respect to healthcare for the citizens of RI. Insurance carriers and the government are becoming increasingly involved with directly and indirectly influencing diagnosis criteria as well as treatment protocols and modalities in the care of our patients. These are changes based on economies of profit for the carriers and expense and control for the government. While some patients will surely benefit from these proposed changes, the vast majority will have their healthcare impacted negatively and told they are better off. The needs of the few, as is becoming the norm, outweigh the rights of the many, and policy is made on this basis. This new "Innovation Plan" reflects the embarrassment of the National foray into deciding what is best for its people, and it is truly embarrassing, even when veiled under the cloak of reform.

John T A Romano, DDS

Dan Meuse <dmeuse@ltgov.state.ri.us>

SHIP Comments on behalf of University Emergency Medicine Foundation

Michael Ryan <mryan@advocacysolutionsllc.com> Fri, Nov 8, 2013 at 10:29 AM
To: shipcomments@ltgov.state.ri.us

Dear Lt. Gov. Roberts:

On behalf of the physicians and staff of the Department of Emergency Medicine at the Alpert Medical School of Brown University we write to comment on the State Healthcare Innovation Plan (SHIP). Our physicians and mid-level providers staff the emergency departments at Rhode Island Hospital, The Miriam Hospital, and Hasbro Children's Hospital.

Specifically, we strongly support improving services for high utilizers of emergency departments, such as the "Sobering Centers" concept mentioned in the SHIP. The over-utilization of emergency services by chronically inebriated individuals has been well documented. At Rhode Island Hospital's Anderson Emergency Center alone, 50 patients with substance abuse accounted for more than 2,800 alcohol-related visits in 2011. Many of these visits are from individuals who have battled alcoholism and other drug addiction for years and whose needs can be met outside of a hospital emergency department.

Providing emergency services to intoxicated individuals in non-emergency situations is costly and inefficient for health-care providers, other emergency-room patients, hospitals, municipalities, and the state. Most strikingly, this cost often ultimately falls to Medicare and Medicaid who reimburse these services on a daily basis.

This current system fails to appropriately treat the individual's underlying substance abuse. The solution is to create a safe, alternative setting, where we can safely and effectively care for these clients and connect them with appropriate treatment. Not only would this approach target the root cause of this cycle of abuse, it would unburden the healthcare system.

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) along with other stakeholders have been developing a three-year pilot program known as the Sobering Treatment Opportunity Program (STOP). The STOP initiative presents an opportunity to safely divert chronically inebriated individuals from the emergency department to a more appropriate, less costly alternative setting.

The SHIP grant could greatly improve the services provided by this program. Specifically, the SHIP grant could help provide outreach services to our homeless alcoholic population to help divert this population away from the healthcare system and into the proposed program. Additionally, partnering with SHIP in this capacity would provide a more comprehensive financial analysis of this national issue and could provide a framework for CMS's approach on a larger scale.

Improving services for high utilizers of emergency room departments will require community-wide collaboration among government, health-care and social-service organizations. We believe the State Health Innovation Plan is an important step in addressing this issue through planning and implementation of best practices.

Warm Regards,

Brian Zink, MD

President, University Emergency Medicine Foundation

Chair, Department of Emergency Medicine, Brown University

Otis Warren, MD

Professor of Medicine (Clinical), Brown University

--
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Dan Meuse <dmeuse@ltgov.state.ri.us>

comments

Greg Gerritt <gerritt@mindspring.com> Thu, Nov 7, 2013 at 11:24 AM
To: shipcomments@ltgov.state.ri.us

On behavioral and substance issues.

Key factor for improvement: Reduce economic inequality in RI by taxing the rich more. Greg gerritt ProsperityForRI.com

Dan Meuse <dmeuse@ltgov.state.ri.us>

Healthcare

Paula Silva <paula.silva8@gmail.com> Thu, Nov 7, 2013 at 10:35 AM
To: shipcomments@ltgov.state.ri.us

Hi,

I do not have healthcare currently one reason being the system seemed so overwhelming to wrap your head around. Also,as an independent contractor and single woman it is just so expensive and I have been a very healthy person my whole life.
I recently attended one of the Healthcare summits at Rhodes of the Pawtuxet for realtors and was impressed with how simple and clearly it was presented on the worksheets provided. I still think it is extremely expensive (I am over 50) and I would definitely like to see more options available like more providers for wholistic wellness care. I have not had any experience on the website or calling the help center so I have no opinion on how that is working.
I will apply but I may take the 1st year penalty till more providers participate bringing more choice and costs down.

Otherwise, I think RI has done a great job in coming up with a clear concise path in this initial rollout.
Thanks,
--
Paula Silva

Lifespan

November 27, 2013

Timothy J. Babineau, MD
President and
Chief Executive Officer, Lifespan

President, Rhode Island Hospital

Professor of Surgery
The Warren Alpert Medical
School of Brown University

Office of the President
593 Eddy Street
Providence, RI 02903

Tel 401 444-5131
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The Honorable Elizabeth Roberts
Lieutenant Governor
State House Room 116
Providence, RI 02903

RE: Rhode Island's State Healthcare Innovation Plan

Dear Lieutenant Governor Roberts:

Thank you for the opportunity to comment on the draft State Health Innovation Plan. We appreciate the considerable work that you have led, as well as the many health care reform efforts currently underway in both the public and private sector. This is indeed a time of unprecedented change and, as the state's largest healthcare system and primary safety net provider, we are pleased to be an active participant in the dialogue.

The plan touches on many goals and approaches about which few could quarrel. For instance, there is little debate about the value of the triple aim. The need to improve patient experience, health outcomes and lower costs are necessary goals whose achievement will address many of the deficiencies of today's health care system. Likewise, we agree that expanding primary care medical homes and encouraging enhanced patient engagement in the care system are also laudable and important goals and we fully support them.

Rather than providing a point-by-point commentary on various aspects of the narrative and elements of the plan, let us offer a few, more select, observations gleaned from a review of the draft and supporting materials.

One observation is the understated toll Rhode Island's prolonged and intractable economic slump has had on the health care system. While acknowledging the importance of economic wellbeing on health outcomes, the plan neither encourages nor supports initiatives sorely needed to advance new policies and plans for economic revitalization. Moreover, population loss (due to the poor economy) and an aging population will likely strain social service capabilities within our state. It seems conceivable that the focus on increased wrap-around social services in the health care delivery system could exacerbate the state's poor fiscal condition sometime in the future, unless successful strategies are implemented to catalyze economic growth. We realize the intent

of the SHIP was not economic development. Nonetheless, the health of the economy and the health of our delivery system are inextricably linked.

Another concern is the over-emphasis of Accountable Care Organizations and ACO like entities (the parameters of which remain undefined in the context of the SHIP) as a prime mechanism to improve health outcomes, standardize care and control cost. There is still little evidence (although it is admittedly early) that these organizations, with their inherent limitations, will deliver on these promises. Other initiatives, some already in the marketplace and others being devised, may offer greater opportunity to achieve the Triple Aim. The state should encourage (and not impede) continued evolution of several different new approaches and strategies and not limit their scope to ACO-like models. Toward this end, a more comprehensive review of existing statutory and regulatory impediments to achieving a number of the stated goals of the Plan is essential to encourage and allow the change required to better align care models. For example, the plan envisions that many patients would be enrolled in systems of care through capitated arrangements. Would fully capitated lives managed by large, multidisciplinary medical groups be regulated under the state's managed care statute? What financial and capitol resources and reserves would be required and would the state subsidize these? These and other questions need to be considered before such arrangements are finalized.

From a financial standpoint, The Plan links investment to systemic savings but the investment from CMS seems a very small part of the dollars that will ultimately be required. Lifespan and other systems are making very substantial investments in technology and other patient management tools with no similar support. For example, over the next 24 months, Lifespan will invest over $100 million to completely redesign its clinical information systems. We believe this is an essential foundation to create the new models of care required to be help enhance quality and control cost. Should this investment be acknowledged and perhaps aided? It is also important to point out that we are making these investments while simultaneously experiencing reduction in program support, burgeoning free care expenses and forecasted negative operating margins for this fiscal year and beyond.

Another concern with the design of Plan is the lack of acknowledgement of the importance of sub-specialty medicine in the co-management of complex medical conditions and their important role in our delivery system. Despite best efforts, people become ill, are victims of traumatic injury and require high end, tertiary care. Successful outcomes of high cost, complex medical cases require medical teams that include specialty and institutional care. The availability and access to these services and interventions are essential—despite high "stand by" costs—and are a critical component of a robust and inclusive system of care

that must be available in our state. Moreover, claims data suggests that these services are provided at an attractive cost when compared with similar services in neighboring states. How these services are supported and paid for (going forward) must be part of any comprehensive system redesign plan. A trauma center must function 24 X 7 X 365 for it to be effective and an acknowledgement of its value and the value of similar tertiary services must be part of any comprehensive plan. Finally, the absence of any acknowledgement of the role academic medicine has played in advancing medical care (not to mention the economy) in our state is a major concern. The lack of discussion for its stable and predictable funding in the future, we believe, is an oversight.

The Plan envisions a substantial reduction in the current funding of the health system. A closer examination reveals that, given current health care expenditures, a sizable portion of the reductions will come from hospitals within the state. Yet the plan is eerily silent on the ramifications of these reductions and the disparate roles some hospitals play in the current safety net, medical training and academics. With so much concern exhibited in recent various regulatory reviews about the economic impact of hospitals on communities, the failure to advance a holistic framework for discussion and impact is troubling.

In closing, we gratefully acknowledge the hard work and collective thinking that has gone into preparing this plan. Any effort that increases the focus and attention on health system redesign is a laudable effort. That said, it is somewhat difficult to assess, with any certainty, the impact the many initiatives articulated in the Plan will have on a system as complex, essential and far reaching as Lifespan. We are a complex organization that anchors the clinical, academic and research enterprise statewide, providing essential health services to nearly half the population of Rhode Island each year. This is an enormous responsibility, one which we take very seriously. The sweeping nature of the Plan is a vision for an enhanced delivery model and we embrace the creation of a more patient centered, value driven system of care. We remain committed to be an active participant in this important dialogue.

Again, thank you again for the opportunity to comment.

Sincerely yours,

Timothy J. Babineau, MD
President and CEO, Lifespan

Blue Cross
Blue Shield
of Rhode Island

500 Exchange Street, Providence, RI 02903-2699
(401) 459-1000 www.BCBSRI.com

November 26, 2013

The Honorable Elizabeth Roberts
Lieutenant Governor
State House Room 116
Providence, RI 02903

RE: Rhode Island's State Healthcare Innovation Plan

Dear Lieutenant Governor Roberts:

Thank you for the opportunity to provide comments on the draft State Healthcare Innovation Plan (SHIP or Plan). First, I would like to acknowledge the work of your office, the multiple state agencies, and various stakeholders that assisted in the creation of the SHIP.

I understand that the SHIP is intended to describe innovations at a high level, focusing on policy ideas and strategic impact and therefore does not include detailed program descriptions and specific plans for implementation at this time. I realize that a more detailed and refined application requesting an innovation grant in the order of magnitude of $40 - $50 million will be submitted to the Center for Medicare and Medicaid Innovation (CMMI) at a later date while the current version of the SHIP will be used as a work product that demonstrates how the initial grant funding from the (CMMI) has been spent. While Blue Cross & Blue Shield of Rhode Island (BCBSRI) firmly supports innovation in our state, at this stage of development, we believe the Plan lacks the specificity, direction, and detail needed to drive meaningful transformation in the State's health care delivery system.

As you know, since my arrival at BCBSRI over 2 ½ years ago, we have dedicated ourselves to working with public and provider partners to transform the delivery system. We share a collective vision of a virtually integrated, high quality, patient-centered system of care that moves away from paying for volume to paying for value. In that time, BCBSRI and key healthcare leaders in our state have made incremental advances in several areas of payment reform, quality improvement programs, care coordination initiatives, and advancing healthcare technology and connectivity. Any success achieved in these initiatives is due to the establishment of well defined, shared, and attainable goals between the various parties. None of the accomplishments, in and of themselves, will make healthcare more affordable or higher quality, but each small innovation we achieve moves us in a meaningful way towards a true "system" of care.

While the Plan's broad description may be a function of CMMI's requirements, we believe the State - and the healthcare stakeholders charged with acting on it - will be best served by a more focused plan with incremental achievements. Therefore, we recommend that the Plan and, ultimately, the innovation grant application, be narrowed to focus on three main areas:

1. Payment and Delivery Innovations and Tools.

Through much investment and various efforts including CSI-RI and BCBSRI's own PCMH initiatives, Rhode Island has become a national leader in primary care transformation. Primary care is the cornerstone of a virtually integrated delivery system. BCBSRI and many of our partners are committed to continuing to drive the adoption of PCMH's; but, we must balance continued investments in primary care and the expansion of PCMHs with efforts to engage sub specialists in transforming their practices if we hope to achieve the goal of having 80% of Rhode Islanders under a value-based payment arrangement within 5 years.

As noted in the Plan, many healthcare providers lack the training, capital, and tools they need to transform their practices. We must give these providers the support they need. In that vein, we recommend that the Rhode Island Care Transformation and Innovation Center (RICTIC) be established with three primary goals.

First, as the Plan acknowledges, providers are at various stages of practice transformation. The RICTIC must identify providers based on where they are in their acceptance of transformation and educate those less inclined toward transformation and value-based contracting about the benefits of these efforts to the provider, their patients, and the system as a whole.

Second, the RICTIC must assist healthcare providers in obtaining and implementing electronic medical records, implementing tools for evidence based medicine, and the training necessary to implement and operate within value-based contracts. Redesigning traditional business models and implementing quality metrics will require significant change and investment in the short-term, but will yield positive long-term results as patient outcomes improve.

Last, the RICTIC can and should drive efforts to establish meaningful quality measures that are standardized across the system and based on evidence based medicine. RICTIC should be created as a non-profit entity that is a shared resource for all. It should serve as a center for data, analytics and informatics to support quality metrics for the entire healthcare delivery system. In addition, the RICTIC should leverage the All Payer Claims Database that is currently under development to minimize administrative burden. This work would facilitate the support needed in the State to harmonize quality metrics across providers, payers and regulators, and serve as the foundation for the State to drive innovation.

2. Expanding the use of Community Health Teams.

Community Health Teams (CHTs) are intended to address the lack of coordination between traditional medical/behavioral care and social services, such as housing, security, education, and food. CHTs could also include social workers, care

coordinators (especially for transitions), and other people involved in social services and health and human services. For primary care practices with only one or two physicians, which make up the majority of primary care practices in Rhode Island, CHTs are a mechanism for providing many of the fundamental functions of a PCMH. Small primary care practices do not have the size or infrastructure to support a full time nurse care manager onsite in their offices. The CHTs could serve that role for a number of practices in different geographic regions of the state. Moreover, these CHTs could also be used to support PCMHs by offering mental health and substance abuse support.

We believe that CHTs can bring significant enhancements to the healthcare system by ensuring compliance with treatment plans and identifying patients at-risk before the risk materializes in order to avoid hospitalizations and serious complications. However, the concept of having the CHTs developed through the use of OHIC's regulatory powers is not the right approach. First, CHTs benefit all Rhode Islanders – many of whom are outside the regulatory power of OHIC. Second, this must be widespread, in multiple communities and will largely benefit Medicaid and Medicare patients. As a result, it is more appropriate to fund the expansion of CHTs through the RICTIC using State and/or federal funds. Of course, payers could be encouraged through OHIC to pay for the services of CHTs as covered services under insurance plans.

The integration of CHTs with primary care providers is critical to their collective success. Therefore, we also recommend that the RICTIC establish a database of available CHTs, implement training programs, and establish mechanisms to connect CHTs with primary care practices so that referrals are seamless, fast and effective and to ensure that information can be easily transmitted.

3. Patient Engagement.

If we are to achieve value-based purchasing of healthcare services, we must ensure that patients understand their role in the healthcare system. As the Plan indicates, there are varying levels of health literacy in the State. We believe health literacy is generally low, and that individuals view the healthcare system not as a way to improve their quality of life, but as something that is there for them when they need it. We must ensure that Rhode Islanders understand the availability of services, how to access those services, and the importance of establishing a relationship with a primary care provider to obtain preventive care and to navigate what will still be a complex system when they need specialty or hospital care.

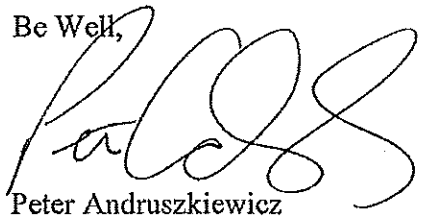
As we develop new tools for transparency and quality, we must ensure that Rhode Islanders understand how to use these tools. And, we must ensure that healthcare providers use the tools as well. We cannot underestimate the effort that is needed to get the word out about how to use a reformed delivery system.

While the three areas of focus above reflect our primary recommendations, we also urge you to rethink the Plan's treatment of Behavioral Health. We agree that cost, access, and quality of behavioral health services must be addressed. We think the Plan would provide a better foundation for future action if it provided expanded and accurate data in the Plan's "current healthcare system" and "healthcare challenges" sections. The Plan indicates the State welcomes additional suggestions for strategies to address behavioral health innovations and we are eager to participate in that conversation. To the extent the Plan concludes that mirrored co-location is the preferred behavioral healthcare innovation, even in the short term, we strongly disagree. It may be one tool, but our experience does not support widespread expansion of co-location. We recommend the Plan retain the reference to CHTs and replace co-location with a proposal to explore integration across a broad spectrum of methodologies, of which co-location may be one, but not the only, option.

In closing, I want to reiterate that no single stakeholder can achieve the goals in the Plan alone. In various areas throughout the Plan it is suggested that if movement is not made or, in some cases, in order to initiate movement, the State will intervene through regulatory processes to force change. The Plan should instead articulate that public/private partnership can lead to innovation and experimentation that will enable new and exciting health care delivery and financing models as well as better, more affordable health care outcomes for the people of Rhode Island We believe the State needs a new kind of health care system; a real system. In order to realize this goal the Plan will need to facilitate and embrace this public/ private partnership to create a new model for collaboration between the State and partners who share largely the same goals.

I hope these comments will be helpful as you finalize the content and the tone of the Plan. BCBSRI is committed to transforming the delivery system with our partners through helping providers build new models of patient centered care delivery and accelerating these efforts through innovative payment arrangements. While our work is ongoing and is not progressing as fast as many of us would like, the level of collaboration and commitment to transforming the delivery system in Rhode Island has never been greater. We must build off of this momentum, accelerate our work and together build a new model for successfully achieving the goals we all share. Thank you for the opportunity to comment on the SHIP. If you have any questions, please do not hesitate to contact me.

Be Well,



Peter Andruszkiewicz
President & CEO

CARE NEW ENGLAND

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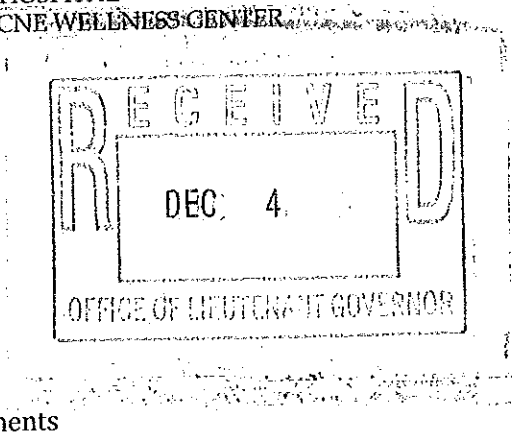

November 26, 2013

The Honorable Elizabeth Roberts
Lieutenant Governor
State of Rhode Island
Room 116
82 Smith Street
Providence, RI 02903

RE: Rhode Island's State Healthcare Innovation Plan Comments

Dear Lieutenant Governor Roberts:

We are grateful to have had the opportunity to participate in Healthy Rhode Island and to provide comment on the draft State Healthcare Innovation Plan (SHIP or Plan). We applaud the work of your office and that of the other state agencies and many stakeholders involved in this Plan's creation.

We believe that participation in the State Innovation Model (SIM) program is a tremendous opportunity for Rhode Island to be inventive and bold in its aim "to achieve measurable improvement in health and productivity of all Rhode Islanders, and achieve better care while decreasing the overall cost of care". Participation in SIM will also support CNE's present development of value based models that promote health, transform care delivery and reduce costs.

We would like to take this opportunity to highlight some of CNE's efforts that may be included in the Plan. CNE is assembling the necessary components to become a certified Medicare accountable care organization (ACO). The recent affiliation with Memorial Hospital (MHRI) will enhance the system's geographic coverage. MHRI's leadership in patient centered medical homes (PCMHs) and internal and family medicine, as well as the partnership with Rhode Island Primary Care Physicians Corporation (RIPCPC), the state's largest IPA; will play an essential role in the CNE integrated delivery system. The affiliation with The Providence Center (TPC) will enable access to all levels of behavioral health care in the CNE system.

CNE has also partnered with Blue Cross Blue Shield of Rhode Island (BCBSRI) to develop innovative delivery and payment models. The five year agreement between CNE and BCBSRI, known as WIN 4 RI, will support progressive arrangements that involve employers and patients in promoting the Triple AIM. The partnership has resulted in roughly twelve proposed initiatives, the first to be implemented will involve a new care management and payment approach for patients who are severely and persistently mentally ill. The next two proposed programs will be an ACO like model for Medicare Advantage and a maternity care global payment pilot. CNE has also worked with BCBSRI in leading the nationally recognized transitions of care work with Healthcentric Advisors.

We recognize that the Plan cannot describe all the activities of stakeholders in the state but would like to underscore some additional examples of our expertise and commitment to healthcare innovation and reform:

- Two individuals from Care New England have been selected to be part of the Centers for Medicare and Medicaid Services' (CMS) Innovation Advisors Program. Chosen were Nancy Roberts, president and chief executive officer of the VNA of Care New England, and Betty Vohr, MD, medical director of the Neonatal Follow-Up Program in the Department of Pediatrics at Women & Infants Hospital and professor of pediatrics at The Warren Alpert Medical School of Brown University.
- CNE has worked closely with the Rhode Island Quality Institute (RIQI) and Current Care to enhance its Center for Medicare & Medicaid Innovation (CMMI) bundled payment program for heart failure and NICU discharge to a medical home.
- CNE has begun to implement Epic as the ambulatory electronic medical record platform to improve integration of CNE-employed and independent physician practices.
- CNE's contract to implement Epic includes an agreement to interface with Current Care.
- CNE is a pioneer sponsor of the Institute of Healthcare Improvement (IHI) work in palliative and end of life care called the Conversation Project.
- Care New England has developed incentives for its employees to enroll in Current Care and has proactively engaged individuals who touch our system toward Current Care enrollment.
- CNE has submitted a CMS Health Care Innovation Round Two application for behavioral health to manage patients with dual-diagnoses.
- CNE has piloted new wellness programs for its employee health plan including significant smoking cessation programs with the Prochaska behavior change research group based at the University of Rhode Island.

We believe the proposed innovations outlined in SHIP are an excellent start. We support the movement toward ACO-like organizations and believe that they offer the best hope for realizing the Triple AIM. CNE welcomes many of the activities described in the Plan especially efforts around health information availability, coordination and access; PCMH expansion, use of community health teams (CHTs) and the development of workforce models. However, we believe the Plan should go even further to advance health transformation in Rhode Island and that we must take this opportunity to do so.

Rather than commenting on every section in the Plan, we have outlined key areas below that we believe would advance true reform.

1. Measures to reduce health care spending must be clearly defined with triggers for rate adjustments should the industry not meet targets.
2. All payers including governmental, providers, the business community and consumers must participate in developing the Plan for meaningful change to occur.

3. Redesign of insured and self-insured products to promote primary care/PCMH arrangements must be incorporated.
4. High deductible plans should be examined as to whether they create appropriate incentives to foster healthcare delivery reform.
5. Patient engagement is crucial to SHIP success; consumer health literacy including education around services, the importance of having a primary care provider and accountability must be incorporated.
6. Behavioral and oral health must not be carved out; inclusion will remove obstacles to effective physical/behavioral health integration.
7. Sub-specialists must be brought in to global risk arrangements and engaged in plans in order to align incentives.
8. There should be a heightened focus on chronic disease management, palliative and end of life care.
9. Rhode Island Care Transformation and Innovation Center (RICTIC) should support the creation of quality and outcome standards based on evidence based medicine and strive for universal application.
10. Opportunities for CNE and other provider systems to connect through Epic should be explored to facilitate involvement in value based plans.
11. Priority must be given to reducing the disparities in care among races, ethnicities and socioeconomic backgrounds; these disparities are mentioned in the application but not prioritized.
12. Plans to care for the undocumented immigrant population should be included in a comprehensive plan.
13. Future opportunities to further centralize some services, such as diabetic education, should be explored once PCMH implementation is to scale in Rhode Island.
14. The development of workforce models should also include a review of incentives and disincentives to practice in Rhode Island which make recruitment a challenge.
15. Financial support is necessary for the accelerated deployment of health information technology including the use of new technologies.

As earlier stated, we support the many existing activities and new interventions outlined in the Plan but recognize that meaningful transformation will only occur if it is truly a collective action. That being said, we are optimistic about the future of healthcare in Rhode Island and our journey toward creating a high performing health care system. We are very grateful for the opportunity to participate in Healthy Rhode Island and wish to convey our enthusiasm for future involvement.

Please feel free to contact me with any questions regarding these comments.
Sincerely,

Dennis D. Keefe

Dennis Keefe
President and Chief Executive Officer

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November 26, 2013

The Honorable Elizabeth Roberts
Lieutenant Governor
State of Rhode Island and Providence Plantations
82 Smith Street, Room 116
Providence, RI 02903

Dear Lt. Governor Roberts:

On behalf of the physician, resident, medical student and Physician Assistant members of the Rhode Island Medical Society I am writing to express our sincere appreciation for your leadership and efforts to reform the health care delivery system in our state. We wish to specifically commend the work of your staff, in particular Deputy Chief of Staff Daniel Meuse, for their tireless work to produce the draft State Healthcare Innovation Plan, SHIP. We are highly encouraged by the extensive stakeholder outreach that has allowed us all to participate in the SHIP design process.

Definitions/terminology

*As we have commented at many of the SIM workgroup meetings, the use of the term Accountable Care Organization, ACO or "ACO-like structures" does not capture the full breath of potential payment models to replace the current fee-for-service model. Nor is it reasonable to think that all physicians will ever be involved in the narrowly defined ACO-like structure. We would suggest mirroring current Medicare related legislation in Congress that uses the more inclusive Alternative Payment Models, (APM) terminology. We should not make the ACO-like structure the only risk bearing payment reform model as we attempt to bend the cost curve.

*Goal 1 on page 36 states that the "primary goal of the SHIP is to transition at least 80% of covered lives in the state into value-based care arrangements." We feel this is an achievable goal as it relates to having those covered lives in a primary care practice that is participating in alternative payment models. However on page 55 under the bullet *Use regulatory and purchasing powers to set contracting standards,* the 80% goal is restated "to require value-based structures for 80% of commercial payments to (all) providers increasing in increments over the next five years." That is a much more difficult and higher standard. One traditional complaint is that the current one-size-fits-all payment system has not provided an affordable or efficient healthcare delivery system. Given that most specialty care is provided in an episodic manner, treating patients from multiple primary care practices, it is very hard to imagine that payment for specialty care could be easily integrated into an ACO-like structure in within the timeframes envisioned. The SHIP draft recognizes that "value-based care is still a relatively young concept. We suggest that the SHIP consistently reflect the covered lives standard.

- "Physician Extenders" is not an appropriate term when discussing the healthcare delivery workforce. As we move through the process of reforming our delivery and payment models to include newer support personnel, e.g. community health workers, we must be mindful that those highly trained professionals such as physician assistants, nurses, social workers, etc. Who provide direct patient care will be functioning in a more "team based" care delivery model. We suggest "advanced practice clinicians" as a more respectful and defining term.

Population health targets:
We agree with most of the targets included in the SHIP draft. In fact, those pertaining to reducing hospital readmissions and ambulatory sensitive emergency room visits are well underway in RI. However, far too many physicians report they often find themselves providing behavioral health services to patients due to the lack of timely and appropriate access to behavioral health services in our state. We include addiction diagnosis in our definition of behavioral health. Because many patients have both physical and behavioral health diagnoses it is imperative that we emphasize improving access and integration of behavioral health in the patient-centered models of primary care.

We would also strongly suggest that increasing access to timely oral health be included in the SHIP.

Rhode Island Care Transformation and Innovation Center, (RICTIC):
Rhode Island is fortunate to have an existing organization that is currently providing many of the resources envisioned in the RICTIC description, Healthcentric Advisors, located at 235 Promenade Street in Providence.

Conduct a workforce assessment:
In order to ensure that Rhode Islanders have sufficient access to the appropriately trained physicians in multiple specialties, from those practicing primary care to specialty care, any workforce assessment must address the complicated issue of adequate distribution of physicians by specialty. We have long experienced difficulty in recruiting and retaining physicians in RI; thus any assessment must consider those factors that have led to this problem.

Behavioral Health:
The quadruple aim of providing the right care, at the right time, in the right place, by the right professional must be applied to the behavioral health issues facing us. There are two overarching issues that we feel must be addressed: full implementation of mental health parity and the payment models of the payers. Many psychiatrists find that they are simply unable to meet the financial needs of operating a small business practice within the current reimbursement models. Co-location strategies are a minimal first step. Access to psychiatric care and an increase in acute care hospital settings are bigger challenges.

Patient Engagement:
The SHIP draft lightly touches upon how patients will interact with the envisioned changes in the healthcare payment and delivery models. One very key component of why our current systems need changing is patient engagement. Patient's lack of understanding of their insurance policy and the structure and interaction of the healthcare delivery system has contributed to the shortcomings of our current systems. In a system where providers will share some level of financial risk with insurers, the patient can be a spoiler. Lack of compliance by a patient will skew data gathering and analyses, health outcomes and ultimately reimbursement.

We look forward to continuing to participate in our state's healthcare reform efforts.

Sincerely,

Elaine C. Jones, MD
President

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Cranston, RI 02920
(401) 946-7887 Fax (401) 946-8188

Edward J. Quinlan
President

November 21, 2013

The Honorable Elizabeth Roberts
Lt. Governor
State of Rhode Island
Room 116
82 Smith Street
Providence, RI 02903

Dear Lt. Gov. Roberts:

We appreciate the opportunity to provide comments on the recently distributed draft State Health Care Innovation Plan (SHIP). The Hospital Association of Rhode Island (HARI) participated in the planning process in recent months, and looks forward to the next stage. With the Plan still in development, our comments complement and expand the opportunities identified in the draft.

High risk (5%) population
HARI has submitted an application to the Rhode Island Department of Labor and Training (DLT) for a community health worker grant, which will help to further strengthen this emerging workforce. Hospitals also recently completed a statewide community health needs assessment, a process by which they have identified opportunities for continued community alliances.

Hospitals have a strong history of collaboration toward a shared goal of quality improvement, and additional opportunities similar to the Rhode Island ICU Collaborative should be examined.

Rising risk (15%) population
HARI recently launched Rhode Island Health Care Matters (www.rihealthcarematters.org). This partnership with the Rhode Island Department of Health offers data and analytics that will assist in tracking improvement in community health.

With the recent launch of HealthSourceRI, it is important that our State supports health insurance plans that provide a focus on primary care and wellness.

Low risk (80%) population
HARI could participate in public marketing campaigns on health care promotion/education to further introduce hospital community health programs and RI Health Care Matters.

HARI may also provide analytic resources for this population.

Behavioral health
Butler Hospital is committed to aligning mental health with primary care, with other hospitals supporting this initiative. Hospitals have identified mental health and substance abuse as a primary goal following the community health needs assessment. Statewide and community-specific implementation plans to improve behavioral health have been adopted.

Data and analytics
HARI established a Data Center several years ago, which has grown in capacity and recognition. We can significantly assist, participate or lead efforts to comprehensively organize a state data center or consortium. This concept was discussed with The Advisory Board.

Workforce
The HARI Center for Health Professions has pioneered workforce research, analysis, training, and academic coordination for 15 years. We stand prepared to build on that foundation.

Sincerely,

Edward J. Quinlan

Edward J. Quinlan
President